Maternal and Child Health Services
Title V Block Grant

State Narrative for Colorado

Application for 2009
Annual Report for 2007

Document Generation Date: Sunday, September 21, 2008

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

The Appropriate Assurances and Certifications for non-construction programs, debarment and suspension, drug-free work place, lobbying, program fraud, and tobacco smoke, that are part of this grant, are maintained on file as required by the block grant guidance at the State's MCH administrative office on the fourth floor at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver, Colorado 80246.

/2008/
No changes //2008//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

Colorado first placed online for review and public input its FY 2000 Maternal and Child Health Block Grant in 1999. Since that time, all narratives have been placed online. Users find online access to the grant very convenient, and comments throughout the year are solicited through a return email function on the Web site.

Much input was sought last year for the FY 2006 grant application through the intensive needs assessment process that was conducted. This process was described in detail in the needs assessment section (Section II).

A draft version of the FY 2007 grant application was placed on the state health department's Web site on June 22, 2006 Comments were solicited by external reviewers and appropriate changes were made in the final grant application before the July 17, 2006 submission.

After transmittal to the Maternal and Child Health Bureau, the final version of the Maternal and Child Health Application/Annual Report for FY 2007 will be available on the department Web site. Visitors to the Web site will be able to download the application and will be able to email the Division with their comments and questions throughout the year. Hard copies will also be available. A map of Colorado is attached to this section to assist the reader when county and place name references are used in the grant application.

/2008/

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A draft version of the FY 2008 grant application was placed on the state health department's Web site on June 26, 2007 Comments were solicited by external reviewers and appropriate changes were made in the final grant application before the July 17, 2007 submission.

After transmittal to the Maternal and Child Health Bureau, the final version of the Maternal and Child Health Application/Annual Report for FY 2008 will be available on the department Web site. Visitors to the Web site will be able to download the application and will be able to email the Division with their comments and questions throughout the year. Hard copies will also be available. A map of Colorado is attached to this section to assist the reader when county and place name references are used in the grant application. //2008//

/2009/ Activities described for 2008 will be done again this year.//2009//

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The 2005 Colorado needs assessment process began with the development of The Health Status of Colorado's Maternal and Child Health Population Report. This coincided with a series of state and local stakeholder input sessions and meetings of a state workgroup. These meeting led to the identified of needs; assessment of the state and local MCH capacity to address these needs; and selection of the top priorities to be addressed with Maternal and Child Health (MCH) funding. The development of strategic plans, which identify specific activities for state and community-level initiatives, began in the spring of 2005.

Guidance for the development of county MCH plans was incorporated into contracts for local health departments. The county public health departments were asked to develop annual MCH plans, setting objectives and activities that addressed one or more of the state's MCH priorities and related performance measures. The state provides county-specific MCH data profiles each year for local public health agencies to use as they developed their annual county MCH plans. The profiles include data for the nearly 30 MCH performance and seven outcome measures where such data were available at the county or regional level.

The local agencies were asked to use the data provided by the state and other relevant data sources when deciding what priorities to address in their MCH Plans. They also submit six-month progress and a year-end final report outlining their successes and challenges in completing the activities and achieving the objectives.

The Health Status of Colorado's Maternal and Child Health Population summarized Colorado data and compared it to national information. Twelve areas associated with women's and children's health needing improvement were identified.

1. Access to prenatal care
2. Alcohol use among pregnant women and teens
3. Low birth weight
4. Immunizations
5. Motor vehicle injury for teens and in rural areas
6. Teen suicide
7. Hispanic teen fertility
8. Access to care for children with special health care needs
9. Lack of access to oral health care for children
10. Lack of insurance for oral health care for children
11. Lack of health insurance for women and children
12. Lack of access to mental health care for children, adolescents, and women.

MCH stakeholders participating in an electronic and phone-based input process reinforced the importance of the issues listed above. The process also identified the following issues of high importance.

•Perinatal period: unintended pregnancy, smoking, inadequate weight gain, drug use during pregnancy, prematurity, infant mortality, and breastfeeding initiation
•Access to health care: lack of insurance for prenatal care; for children and especially those with special health care needs; and lack of access to family planning for adolescents and young women
•Secondhand smoke exposure

•Intentional (child abuse and neglect) and unintentional injury among children
•Overweight among women and children
•Adolescent smoking, alcohol and illegal substance use

The workgroups associated with the planning process identified focus areas relevant to specific populations or types of services to address when working on a priority need. For example, under the Access to Care priority, there are four focus areas that will be addressed in the development of the strategic plan for that priority need. They include access to primary care for all children; access to specialty care for children and youth; access to mental health services for children, youth and women; and access to oral health care for children. The ten state performance measures selected are discussed in the Priorities, Performance and Program Activities Section.

The ten priority needs address all three major MCH population groups. Preventive and primary care for women, mothers and infants are addressed through eight of the priorities. Preventive and primary care for children are addressed through nine of the priorities. Services for children with special health care needs are addressed through two of the priorities.

Current activities
In the last year, the program has been developing state level plans that address the ten priority areas.

Work is under way to review current activities and ensure they are still relevant based upon data and state needs. Staff are working to clarify their focus within three program areas thus ensuring the most benefit from MCH funding and activities.

Another major initiative influencing work this year was the development of a MCH Planning Process Workgroup. The MCH Director convened the workgroup to examine how to improve planning systems and processes associated with the use and distribution of MCH funding to local contractors.

The Workgroup met six times from June through September 2006, and drafted 20 recommendations. As a result of this process, three smaller workgroups (Strategic Planning, Model Plans, and Training & Technical Assistance) composed of state and local MCH staff were convened. These groups are working to operationalize and then implement the recommendations from the report. (Attachment). Additionally, state staff are engaging in a critical review of state-level MCH activities during the summer and fall to better re-define priorities and work at the state level in response to data trends and MCH funding reductions.

/2009/MCH Local Planning Process Improvement. MCH state staff successfully completed an 18-month collaborative effort with local public health partners to revise the MCH local planning process. The goal was to promote a systematic process of planning, implementation and evaluation for use in the development of MCH plans at the local level and to assure that plans were in alignment with the MCH performance measures. Over the course of the next three years, all local agencies will move to completing a 3-year MCH plan with annual updates. To this end, processes and forms were jointly crafted to assure that data were available for use in decision-making and joint state and local planning processes were implemented to assure that local plans utilized evidence-based and/or promising practice strategies with explicit goals, objectives, and activities. The importance of both process and outcome evaluation was highlighted throughout the work group process. Local agencies will complete their plans utilizing this new process as of 7/1/08. Detailed instructions are included within the MCH Guidelines located at www.mchcolorado.com and at www.hcpcolorado.com.

A state-level trend analysis was developed (attached). //2009//

An attachment is included in this section.

III. State Overview

A. Overview

Introduction

The Rocky Mountain state of Colorado is bounded on the east by Kansas and Nebraska, on the north by Nebraska and Wyoming, on the west by Utah and on the south by New Mexico and Oklahoma. The boundary lines create an almost perfect rectangle, measuring approximately 387 miles from east to west and 276 miles from north to south, covering 104,247 square miles. Colorado is the eighth largest state and consists of mountains, plateaus, canyons, and plains. The eastern half of the state has flat, high plains and rolling prairies that gradually rise westward to the front range foothills and the higher ranges of the Rocky Mountains. The Continental Divide runs from north to south through west central Colorado and bisects the state into eastern and western slopes. The western half of the state consists of alpine terrain interspersed with wide valleys, rugged canyons, high plateaus and deep basins.

The state can be divided into five distinctive regions within its 64 counties: the Front Range, the Western Slope, the Eastern plains, the Eastern mountains, and the San Luis Valley. Each of these areas has grown in population, ranging from a 15 percent increase in the San Luis Valley from 1990 through 2000 to a 38 percent increase on the Western Slope. Close to 82 percent of the population lives in the Front Range, which includes the metropolitan areas of Denver-Boulder, Ft. Collins, Greeley, Colorado Springs, and Pueblo. The San Luis Valley in the southern part of the state is the region with the smallest population, with about 46,000 residents. Over fifteen percent of Colorado residents are considered rural residents, living outside core urban areas and areas adjacent to an urban core. Yet, close to 40 percent of these rural residents live in the urbanized Front Range counties. The rural vastness of much of the state is confirmed by 23 of Colorado's 63 counties in the 2000 Census qualifying as "frontier counties," containing fewer than 6 persons per square mile. The mountain range separating the populated Front Range from the more rural areas of the Western Slope, Eastern Mountains, and San Luis Valley makes the delivery of health care more difficult to those in these rural areas.

In 2001, one additional county was added to the existing 63: Broomfield County consists of areas formerly in the urban counties of Adams, Boulder, Jefferson, and Weld. Each of the 64 counties within Colorado has its own local government. There are 15 organized health departments covering 24 counties. In addition, 39 county nursing services provide services to the remaining 40 counties.

Population

The population of Colorado is estimated at 4,647,321 in 2005, an increase of 346,060 since the 2000 Census enumerated the state's population at 4,301,261. Average annual growth in recent years has been 1.6 percent, down from the 2.7 rate of the 1990s, but high enough to make Colorado still one of the fastest growing states.

The two major racial and ethnic groups in Colorado are White non-Hispanic and Hispanic. In the 2000 Census, 74.5 percent of the population identified themselves as White non-Hispanic, 17.1 percent identified themselves as Hispanic, and 8.4 percent identified themselves as not Hispanic and not White. Among all racial groups (not considering Hispanic ethnicity which is generally included under White), 82.9 percent of the population was White; 3.8 percent was African-American or Black; 2.2 percent was Asian; 1.0 percent was American Indian; 0.1 percent was Native Hawaiian or Pacific Islander; 7.2 percent was some other race; and 2.8 percent were persons belonging to two or more racial groups.

The Hispanic population has grown rapidly in recent years; from 735,601 in 2000 to an estimated 876,800 in 2005. Much of the increase in the Hispanic population is made up of United States

citizens and immigrants who are in the United States legally, but some substantial but unknown amount of growth consists of undocumented workers and their families who are not legal residents.

The total number of births in Colorado has also increased rapidly in recent years. In 2000 there were 65,429 births, which grew to 69,305 in 2003. The number of deaths has changed as well over this time period. In 2000 there were 27,229 deaths which grew to 29,410 in 2003. It is important to note that migration has also been an important factor in the state's population growth in recent years. Between 2000 and 2005, net migration is estimated to have added an additional 195,000 residents.

According to the 2003 American Community Survey, the Census Bureau's most up-to-date annual survey, 15 percent of children and adults spoke a language other than English. For both children and adults, Spanish was the main other language spoken with 12 percent of school-aged children and 11 percent of adults able to speak Spanish. The survey estimated that from 3 to 5 percent of households in Colorado were linguistically isolated, i.e., that all members 14 years and older had at least some difficulty with English.

Estimates by the Colorado Department of Local Affairs suggest that almost 21 percent of the population in 2005 (992,490) are women of reproductive age (15-44). Approximately 29 percent or 1.3 million are children 19 and younger. The number of women of reproductive age is projected to grow by over 10 percent in the next ten years to close to 1.1 million; the number of children in the state is projected to grow by over 15 percent in that same time period to close to 1.5 million.

Economy

With the influx of population in the 1990s, Colorado experienced an increase of over 42 percent in employment growth from 1990 through 2003, making it the 5th highest state in employment growth during that time, much higher than the national average of 19 percent. Colorado saw record low unemployment in 2000, but the economy began a downturn in 2001. The years 2002 and 2003 were recession years for the state, and recovery, beginning in 2004, has been slow. The April 2005 unemployment rate stands at 5.2 percent, compared to 6.1 percent in July 2003 and a record low of 2.7 percent in 2000.

In 2003, 9.8 percent of the population in Colorado was estimated to be living below the poverty level; 11.5 percent of children 5 to 17 and 16.4 percent of children under 5. The poverty rate for the state's largest minority population, those of Hispanic origin, was estimated at 16 percent, and one in 5 Hispanic children age 0 to 17 lived in households below the poverty level. While the American Community Survey did not estimate the poverty rate for women of reproductive age by race and ethnicity, the 2000 Census reported that 21 percent of all Hispanic women of reproductive age lived below the poverty level.

Health Care Access

Colorado ranked 37th in the proportion of residents with health insurance coverage among all states in 2003. A total of 16.2 percent of all Colorado residents and 13.7 percent of Colorado's children were without health insurance in that year; Colorado's ranking for children with health insurance coverage was 43rd among all states. Furthermore, about one-quarter of women under the age of 35 are without insurance. About one-third of women giving birth each year receive coverage for prenatal care through Medicaid; this proportion has increased in recent years. About 1 in 6 children in the state are covered by Medicaid. In addition, the Colorado Child Health Plan Plus program covers about one in every 15 children in the state.

Community health centers (CHCs) are an important source of care for low-income residents, both

Medicaid-eligible, Child Health Plan Plus-eligible, and those who are uninsured or underinsured. However, CHCs are not available in all communities that have populations in need and lack sufficient capacity to meet the need in many communities where they do exist.

Many children or adolescents need some form of mental health care or counseling, but the majority do not receive help. Not only is access to care not assured, services are not available in many areas of the state.

Additionally, oral health access continues to be a challenge, especially for uninsured or children enrolled in Medicaid. Hispanic children, compared to White, non-Hispanic children, had a significantly higher proportion of existing dental caries and untreated decay. Less than one in six Hispanic third graders had dental sealants, half the level of White non-Hispanic children. About 75 percent of Coloradans on public water systems have access to fluoridated water, but well over half a million state residents do not drink fluoridated water. A full report, The Impact of Oral Disease on the Health of Coloradans, can be found at www.cdphe.state.co.us/pp/oralhealth/Impact.pdf.

Title V has in place systems to determine the importance, magnitude, value, and priority of competing factors impacting health services delivery in the state. State and local-level MCH staff are involved in priority setting and planning to meet these needs. The system is described in detail in Section II.

/2007/

Colorado's population continued to grow between 2005 and 2006, reaching an estimated 4,719,923 and continuing the 1.6 percent annual growth rate of the new decade. While the number of births in the state fell by 1.2 percent between 2003 and 2004, preliminary data for 2005 show a small increase between 2004 and 2005.

Unemployment figures this year show improvements below the final rate of 5.0 percent in 2005. In February 2006, the rate reached a low of 4.3 percent.

Colorado's ranking for health insurance coverage was 36th in 2004 (United Health Foundation, 2004), similar to the state ranking of 37th in 2003. The percentage of the population without insurance was 17.1--one in six persons.

The state's ranking on the percentage of children with health insurance was 46th, tied with Arizona (American Academy of Pediatrics, 2005). Only three states had lower (worse) rates: Florida, Nevada, and Texas. A total of 15.1 percent of children under 18 were without insurance in 2004--one in seven children in the state. //2007//

/2008/

Colorado's population is now approaching 5 million, with an estimate of 4,902,323 projected as of July 1, 2007. This number results from an average annual growth rate of 2.0 percent since 2000, when the population according to the Census was 4,301,261. The number of births in 2006 is estimated at 70,500, up from 2005, when they totaled 68,922, and a considerable increase since 2000, when they totaled 65,429. The total number of deaths in 2006 is estimated at 29,500. Annual net migration for the period 2006 to 2007 is estimated at 54,000, contributing more to growth in the state than the number due to natural increase (births minus deaths, or approximately 41,000).

Colorado's economy performed well in 2006, with an unemployment rate of 4.3 percent. In April 2007, the most recent month for which data were available at the time of this writing, the rate had fallen further to 3.4 percent.

Colorado's ranking for health insurance coverage improved slightly from 36th in 2004 to 35th in 2006 (United Health Foundation). The percentage of the population without insurance was 17.0--one in six persons. The Colorado Blue Ribbon Commission on Health Care Reform is presently studying a number of proposals to provide health coverage to more Coloradans.

The state's ranking for the percentage of children with health insurance inched up from 46th in 2005 to 44th in 2006 (American Academy of Pediatrics, September, 2006). Six states had lower (worse) rates of uninsurance: Arizona, California, Florida, Nevada, New Mexico, and Texas. A total of 13.5 percent of children under the age of 18 were without insurance in 2005--one in every seven children in the state according to the Academy.

Colorado's child immunization rates improved substantially according to the most recent figures. Colorado ranked last among the 50 states in 2002, when its immunization rate for children age 19-35 months was 56 percent. By 2005, Colorado had jumped to 16th place, with 79 percent of children fully immunized. //2008//

/2009/

In July 2008 Colorado's population reached the 5 million mark, with an estimated 5,008,259 residents. Births in 2007 totaled over 70,700; deaths totaled 29,800, and net migration was estimated at 65,000.

Colorado's economy has experienced increasing unemployment since this grant was written one year ago in the spring of 2007. The unemployment rate has been increasing since April 2007, and the February 2008 rate of 4.4 percent is the highest level seen since August 2006.

Colorado's ranking for health insurance coverage is 36th out of 50 states. A total of 17.2 percent of the population is uninsured.

The percentage of children who are without health insurance appears to be declining, according to the Colorado Child Health Survey. Calendar year 2004 data showed a rate of 12.6 percent; 2003 data showed 11.9 percent, and 2004 data showed 10.2 percent without insurance. //2009//

B. Agency Capacity

The MCH Section works with other state health department divisions and programs to promote and protect the health of all mothers and children, including children with special health care needs. The State Overview, Section III A, describes the characteristics of Colorado's population and lays out some of the challenges currently facing the state. This section provides information on the state health department's capacity to carry out its mission. The following section, organized under four headings, describes the Health Care Program for Children with Special Needs (HCP).

HCP is contained within the Children and Youth with Special Health Care Needs Section, which was created in late 2003. (See III B attachment for organizational chart). Other components of the section are Genetics and Newborn Screening, the Medical Home Initiative, the Data Integration Program, and the Newborn Hearing Program. Activities within HCP that support local and state efforts are described below. The text also describes other programs that make up the infrastructure for HCP to carry out the six MCH national performance measures directed at

children and youth with special health care needs.

1. State Program Collaboration with Other State Agencies and Private Organizations for Children with Special Health Care Needs
The Health Care Program for Children with Special Needs works closely with Part C Early Childhood Connections at the Colorado Department of Education to implement HCP care coordination standards, and to define respective roles in serving infants and toddlers with special health care needs. (The care coordination standards are also provided in the III B attachment). As a part of the collaboration, Part C staff are changing policies and procedures for serving infants in neonatal intensive care units. The HCP Program will be included in the initial referral process to help decide family medical and health needs and to determine the role of HCP in meeting those needs.

HCP is also beginning to use the care coordination standards in work with the Medicaid EPSDT Outreach program, thus helping to maximize EPSDT outreach services. The care coordination standards are also used with children receiving clinic services, the Colorado Responds to Children with Special Needs birth defects registry, and in the infant hearing screening followup.

The Medical Home Initiative, which began in 2000, is another example of state collaboration. The initiative is led by the Children and Youth with Special Needs Section and is designed to address the medical home national performance measure. The initiative consists of a state strategic planning group and the Medical Home Advisory Board. The Board includes staff from the state advocacy group, the University of Colorado Health Sciences Center, the Colorado Department of Education, mental health providers, health care financing experts, and pediatricians.

HCP works with JFK Partners, which is the Leadership Enhancement in Neurological Disabilities (LEND) grantee at the Health Sciences Center, to ensure that higher education and research are supporting Title V goals.

Public health genetics services, administered or supported by governmental agencies, require a unique kind of "buy-in" and support from nongovernmental and private sector partners. The sanction of activities in public health genetics is necessary because the public is fearful of a potential loss of privacy regarding health matters, and is wary of the potential for broad discrimination based on the misuse of genetic information. These issues are further exacerbated by a questioning of the government's role in this arena. To address these challenges, HCP calls on a diverse group of medical and public health professionals, scientists, policymakers, and consumers from all major organizations in Colorado that are involved in work in genetics. The Colorado State Genetics Advisory Committee meets bimonthly to provide expert advice, review, and consultation to the state Genetics Program. The committee also ensures communication, coordination, and collaboration among the individuals and programs whose work in genetics may affect the public's health and right to privacy.

The HCP state family consultant works with a number of state agencies to establish relationships, develop memorandums of understanding, and to be available for technical assistance and follow up. Local implementation of the memorandums are facilitated by HCP's regional family coordinators who are members of HCP's multidisciplinary teams in all 14 regional offices.

/2007/In December 2005 the lead agency designation for Part C in Colorado was changed by the Governor's Executive Order. For 18 years the lead agency was the Department of Education. It is now the Department of Human Services, Division of Developmental Disabilities. The Children with Special Health Care Needs Section will continue to be represented on the state Interagency Coordinating Council and will promote their role in the Early Intervention system with the new state and local Part C personnel.

The Early Hearing Detection and Intervention grant is one of the programs in the Children and Youth with Special Health Care Needs Section. This project integrates newborn hearing, newborn

metabolic screening and the Colorado Responds to Children with Special Needs birth defects registry data. The IT system began this spring and will de-duplicate records for more efficient follow-up, reducing duplicate contacts for families. The project has also developed database software for numerous agencies including the metabolic clinics at The Children's Hospital, the HCP program, and the Traumatic Brain Injury program. Future integrating of data sources for a more complete surveillance of children with special health care needs is planned.

The Colorado Medical Home Initiative has broadened its scope to assure a medical home approach for all children. The Medical Home Learning Collaborative is working with The Children's Hospital to increase the percentage of children enrolled in Medicaid and Child Health Plan Plus served in specific pediatric practices. Colorado is also combining the Medical Home Initiative with a state systems of care grant awarded through the Substance Abuse and Mental Health Services Administration. The Linking and Aligning Task Force is developing long and short-term plans. HCP is also beginning to link with The Children's Hospital oral health efforts to assure oral health is coordinated with primary care. //2007//

/2008/ CYSHCN staff worked with Part C and Children Adolescent and School Health staff to implement the Assuring Better Child Health and Development Project that will increase the use of standardized developmental screening in primary care practices. //2008//

/2009/ The structure of the Developmental Evaluation Clinic program, which had been partially supported by ECC for many years, changed to a HCP Specialty Clinic model.

The Unit continued work with the CDPHE Lab to increase effectiveness and efficiency of newborn screening and follow-up. An attempt was made to increase the screening fee so that The Children's Hospital contractors can increase their capacity to meet the increased demand that was created with Tandem Mass Spectrometry. Ir was not approved and a fee increase will be sought again next year.//2009//

2. State Support for Communities for Children with Special Health Care Needs
The Health Care Program for Children with Special Needs program structure consists of a state office that supports all 64 counties in Colorado. Fourteen organized health departments serve as HCP regional offices for the other three smaller health departments and for the 39 county nursing services. All receive direct financial support through contracts with the state HCP office. With state office technical support, the 14 HCP regional offices provide administration and technical assistance to the small health departments and nursing agencies. This structure creates a strong network with personnel in every county of the state who are dedicated to serving children and youth with special health care needs. A map showing the regions is contained in the III B attachment.

Each regional office has a multi-disciplinary team of coordinators. Teams are made up of team leaders, parent/family coordinators, nurses, social workers, audiologists, speech pathologists, occupational therapists, physical therapists, vision coordinators, and nutritionists. The team provides support to the regional office, particularly in the areas of care coordination and infrastructure-building. The nurse care coordinator may delegate care coordination activities to another discipline, or seek consultation from another discipline to expedite the coordination of services. See the attachment for a description of the regional coordinator's scope of work.

Discipline coordinators have natural connections in communities that allow for the development of improved processes across agencies, as well as the ability to convene appropriate groups to address community needs. Each discipline coordinator on the team receives technical support through the state level same discipline consultant who is a state and sometimes a national leader in his field of study.

The state office also provides assistance with assessment, planning and evaluation for the

regional offices. An electronic tool has been developed for local offices to help them with the planning process. Called HERMAN, HCP End of the Year Report and MCH Plan, this tool assures that attention is paid to the six national performance measures for children and youth with special health care needs. HCP also provides a state comparison of county/regional data to assist the regional offices in their planning efforts. Jefferson County's report is provided as an example at the end of the III B attachment. Finally, HCP has surveyed the regional offices to determine topics to pursue in the future through the learning community format.

/2007/Regional care coordination and community infrastructure efforts are documented in a newly designed database, called HCP Clinical Health Information and Records for Patients. The state office supports local staff by providing a Help Line, training, and enhancements to improve data collection associated with the database. The HCP End of the Year Report and MCH Plan have been updated and are more user-friendly and efficient. The Section's Data Analyst has enhanced the Section's ability to collect, manage and use data. //2007//

/2008/ The HCP local planning and reporting processes are being simplified. The HERMAN tool will be discontinued. //2008//

/2009/ A Medical Home Approach Action Guide was developed as a resource for local HCP programs. The guide encompasses the three services provided by all offices - care coordination, connection of primary and specialty care, and interagency collaboration. //2009//

3. Coordination with Health Components of Community-Based Systems for Children with Special Health Care Needs

Public health nurses and HCP's regional multidisciplinary teams work to assure that there is coordination at the local level among the services needed by families and children. Since HCP no longer provides direct care, local resources have shifted to providing care coordination services, population-based services, and to building public health infrastructure. All local HCP agencies provide resource and referral information regarding children and youth health services to the entire population. Each HCP agency provides care coordination services to targeted populations depending on community need, capacity, and reimbursement.

The Children and Youth with Special Health Care Needs Section employs a developmental pediatrician through the University of Colorado Health Sciences Center. The pediatrician works with the HCP Program and the University, training medical residents and providing public education to agencies, organizations and health care providers regarding diagnoses, the system of services, and HCP's public health role.

In the western part of the state, the Western Slope HCP regional office provides Level II and Level III care coordination in the community, assisted by state HCP office support. The Rocky Mountain Health Plan reimburses this work.

HCP provides consultation to community and regional teams for children with nutrition, feeding, and growth concerns. As a result, one Diagnostic and Evaluation Clinic has added a "feeding focus" with nutrition feeding assessments and diagnoses as part of the team's activities. This service is a collaborative effort with The Children's Hospital in Denver, local hospitals, the state health department, Early Intervention Services, the child's primary care provider, the regional developmental pediatrician, community therapists, and registered dietitians. Adding a feeding focus to additional Diagnostic and Evaluation Clinics is being evaluated.

HCP provides strong support to a statewide clinic system that is a coordination of local and state resources. HCP-sponsored clinic programs provide access to specialty medical care, genetic, and diagnostic and evaluation services. These clinics are important in assuring that families have access to specialized pediatric health services in rural and frontier areas of the state.

/2007/ No changes. //2007//

/2008/ No changes. //2008//

/2009/HCP rural specialty clinics continued to focus on existing priority issues in their communities. They also emphasize medical home components, particularly the coordination between specialists and primary care providers.

The Developmental Evaluation (D&E) clinic model was made more consistent with how other HCP rural specialty clinics operate. The ongoing need for medical developmental evaluations is being addressed with Early Childhood Connections, CHILD FIND and local primary care providers.//2009//

4. Coordination of Health Services with Other Services at the Community Level for Children with Special Health Care Needs
Since July 2004, the Colorado Department of Human Services has contracted with the HCP Program to provide care coordination through local offices to families of children with traumatic brain injury. The HCP Program was selected because it is the sole statewide entity with the children's services system in Colorado that can effectively connect health services with other services. Funding for this service is provided through a Traumatic Brain Injury Trust Fund created in 2002 supported by alcohol and speeding citations and fines.

Local HCP staff work closely with Part C coordinators to assure that health-related early intervention services are coordinated. Most local HCP staff are also involved in other interagency work such as serving on child protection teams, working with school districts to support parents in special education staffing, and developing Individual Education Plans or Individual Family Service Plans. HCP provides strong support to a statewide clinic system that is a coordination of local and state resources. HCP-sponsored clinic programs provide access to specialty medical care, genetic, and diagnostic and evaluation services. These clinics are important in assuring that families have access to specialized pediatric health services in rural and frontier areas of the state.

/2007/The HCP Traumatic Brain Injury Care Coordination Program was evaluated by external auditors regarding family satisfaction. Concurrently, an internal audit of ability to meet contractual obligations and quality assurance regarding services rendered were also completed. Chart audits and client surveys showed the program is very successful. This evaluation also helped to identify areas of needed development, such as the HCP care coordination role with the schools.

The Children with Special Health Care Needs Section has increased its emphasis on community development and partnerships with non-traditional partners. Examples include the Faith-Based Task Force, replication of community Respite Care Centers and community Transition Fairs. //2007//

/2008/ No Changes//2008//
/2009/ No Changes//2009//

State Statutes Relevant to Title V Programs
/2009/ Senate Bill 07-130 requires the Department of Health Care Policy and Financing (HCPF) to work collaboratively with the Colorado Medical Home Initiative (CMHI) to develop medical home practice standards and to increase the number of Medical Homes for children eligible for Medicaid and CHP+.

Senate Bill160, Concerning Improvements to Health Care for Children expands and

simplifies health insurance coverage through Medicaid and the Child Health Plan Plus (CHP+) and raise CHP+ eligibility from 205 to 225 percent of the Federal Poverty Level (FPL). Eligibility can be expanded up to 250 percent of the FPL if additional funds are appropriated. The bill also expands the CHP+ mental health benefit so that it is equivalent to that found in Medicaid.

Senate Bill161, Concerning Eligibility for Public Medical Benefits, reduces barriers to enrollment in Medicaid and CHP+ for currently eligible children. SB161 eliminates the requirements for families to submit paycheck stubs and instead uses available data through the Department of Labor and Employment (DOLE) to verify a family's income. DOLE data may also be used for reenrollment. It also directs an existing advisory committee to explore the feasibility of combining the Medicaid and CHP+ programs

Senate Bill 22, Concerning Over Expenditures in Children's Basic Health Plan, allows, with the governor's approval, expenditures of the Department of Health Care Policy and Financing to exceed their appropriations for the Children's Basic Health Plan.

The Autism and the Behavioral Health Commissions are identifying systemic barriers and best practices for the identification, treatment and coordination of services for these sub-populations of CSHCN. A budget request to fully fund the Colorado Immunization Information System was approved. //2009//

State Title V Capacity to Provide a Variety of Services
A description of programs receiving some MCH funds that influence Title V's capacity to provide various services is provided below:

1. Preventive and Primary Care Services for Pregnant Women, Mothers and Infants
The Women's Health Section provides a small amount of funding for direct clinical prenatal care in communities where uninsured women would otherwise not be served. The Section's activities are primarily directed toward enabling- and population-based services for women, and are offered through organized health departments, community health centers, and local nursing services. Services include smoking cessation and nutrition counseling provided through the Medicaid-funded Prenatal Plus Program. Funding will cease for direct prenatal care beginning in FY 2006, due to reduced funding levels and the focus on more population-based services.

The Nurse Family Partnership Program provides intensive nurse home visitation to first-time low-income mothers during the prenatal period up to the child's second birthday. The Prenatal Plus Program provides case management services for high-risk Medicaid-eligible pregnant women. It is a Medicaid-funded program that provides case management, nutrition, and psychosocial services to pregnant women who are assessed to be at high risk for delivering low birth weight infants.

In 2000 the Women's Health Section released a report that showed that one of the contributing factors to the high rate of low birth weight infants in Colorado was inadequate weight gain among 25 percent of pregnant women. The report led to the initiation of a statewide campaign to promote adequate weight gain during pregnancy. The campaign uses social marketing techniques, targeted materials, training, and an informational website to reach out to prenatal care providers and consumers.

/2008/ The Women's Health Unit worked with the Diabetes Program to develop comprehensive guidelines for the diagnosis and treatment of gestational diabetes and provided regional training. The Nurse Home Visitor Program is now part of this Unit. The message for the social marketing campaign regarding adequate prenatal weight gain was expanded to include prenatal smoking cessation. Additional projects include a multidisciplinary team approach to increase screening and treatment for postpartum depression and other mood disorders; and an Action Learning Lab

for Smoking Cessation in Women of Reproductive Health Age. //2008//

/2009/ The Women's Health Unit continued to collaboration with the Diabetes Program to promote utilization of comprehensive clinical guidelines for the diagnosis and treatment of gestational diabetes and will provide technical assistance to healthcare providers. The Nurse Home Visitor Program and Prenatal Plus Programs engaged in planning to sponsor a joint statewide conference. A multidisciplinary team approach to increase screening and referral for postpartum depression and other mood disorders is being developed in the Prenatal Plus Program. The message for the Healthy Baby social marketing campaign emphasizes both appropriate prenatal weight gain and prenatal smoking cessation. An Action Guide was developed for use by local health agencies in implementing the campaign. Collaborative partnerships have been formalized externally through Colorado Clinical Guidelines Collaborative and within the department with a division project team to increase efforts to address prenatal smoking cessation.//2009//

2. Preventive and Primary Care Services for Children/2007/
This section has been revised from last year's FY 2006 grant. The Child, Adolescent, and School Health (CASH) Section leads efforts to improve the health and well-being of all Colorado children and adolescents through health promotion, public health prevention programs and access to health care. The Section is comprised of both CASH-MCH team members and related programs that impact the child and adolescent population. The CASH-MCH team includes the Adolescent Health Program Director, the Early Childhood Program Director, the Nurse Consultant for School-Age Children, the School-Based Health Center/Coordinated School Health Director, and the Section Director. This team provides leadership in setting priorities; identifying and promoting best practices to address the priorities; and working with local public health, schools and other state and community partners to develop and implement comprehensive, coordinated strategies to improve the health of children and adolescents.

The Section administers a variety of state and federally funded programs to address the needs of children, teens and families. One is the Nurse-Family Partnership Program, implementing nurse home visits for first time low-income pregnant women and their children through the child's second birthday. Another is the Colorado Children's Trust Fund, with the mission of child abuse prevention and the support of the "Nurturing Parenting Program." The Family Resource Center Program supports resource centers in communities across the state to assist families with a variety of needs. The Tony Grampsas Youth Services Program supports local non-profit organizations to prevent youth crime and violence, as well as child abuse. These funds support early childhood programs, student drop-out prevention programs, youth mentoring, restorative justice, after-school programs, as well as a variety of other programs targeting high-risk youth and families. Smart Start Colorado is a statewide alliance of early childhood partnerships working together to create a comprehensive system for young children birth to age eight and their families.

The School-Based Health Centers Program and the Colorado Association for School-Based Health Care convene, facilitate, and provide technical assistance to schools and provider agencies that develop, implement, and support school-based health centers. The Coordinated School Health Initiative is CDC-funded partnership to build state and local infrastructure to support the coordinated school health model, with an emphasis on nutrition, physical activity and tobacco prevention.

Advisory groups for the Section include the Advisory Council on Adolescent and the Youth Partnership for Health. The Advisory Council on Adolescent Health is an interdisciplinary group of adolescent health experts and community advocates, who advise the Colorado Department of Public Health and Environment, educate and inform the public, and advocate for policies and programs to improve the health and well-being of all Colorado adolescents. It includes inter- and intra-agency members. The Youth Partnership for Health is composed of 25 teens recruited from

all areas of Colorado. The partnership advises the state health department on policies and programs that affect adolescents.

The Section works closely with other department programs: Injury and Suicide Prevention; Colorado Physical Activity and Nutrition; Immunizations; Interagency Prevention Systems; Women's Health; Tobacco; Children with Special Health Care Needs; Oral, Rural and Primary Care; Abstinence Education; Chronic Disease; and numerous other Departmental entities. Other efforts include close collaboration with the Department of Human Services (the Alcohol and Drug Abuse Division, Mental Health, Child Care, Youth Services and Child Protection); the Department of Transportation; the Department of Education (Coordinated School Health, school nursing, special education, early childhood and other prevention initiatives); the Department of Public Safety; the Cooperative Extension Program; higher education; and professional organizations such as the Rocky Mountain Chapter of the Society for Adolescent and the Colorado Chapter of the American Academy of Pediatrics. //2007//

/2008/ As part of a larger redesign of the Prevention Services Division, three programs have moved out of the Child, Adolescent and School Health Unit. The Colorado Children's Trust Fund and the Family Resource Center Program moved to the Injury, Suicide and Violence Prevention Unit. The Nurse-Family Partnership Program moved to the Women's Health Unit. The Child, Adolescent and School Health Unit continued to work with these programs.

The CASH and HCP Units are working to implement the Assuring Better Child Health and Development Project that focuses on promoting the use of standardized developmental screening tools in primary health care settings to help increase early identification of developmental concerns.

Colorado's new Lieutenant Governor has identified early childhood issues as a top priority and is committed to building on the work achieved through Smart Start Colorado and Colorado's Early Childhood Comprehensive Systems Grant from MCHB. To facilitate efforts, the Smart Start Colorado Director is now physically located within the Office of the Lieutenant Governor but is still a CDPHE employee. //2008//

/2009/Colorado is experiencing a period of increased interest and investment in school health. The School-Based Health Center Program, located within the Child, Adolescent and School Health (CASH) Unit, has received one million dollars from a private foundation to support school-based health centers throughout Colorado. In addition, another private foundation is supporting a part-time technical assistance consultant, housed in the CASH Unit, to complete an assessment of technical assistance needs of school-based health centers. This assessment will help inform future public-private collaborations to support an effective technical assistance infrastructure for school-based health centers in Colorado. In addition to private foundation support, the Colorado state legislature increased school-based health center funding from $500,000 to one million dollars. Colorado has been awarded another five-year cycle of funding for the Coordinated School Health Program from the Centers for Disease Control and Prevention. A school health team, within the CASH Unit has been formed to maximize integration between the School-Based Health Center Program and the Coordinate School Health Program. //2009//

3. Services for Children with Special Health Care Needs

The Health Care Program for Children with Special Health Care (HCP), within the Children and Youth with Special Health Care Needs Section of the Colorado Department of Public Health and Environment, is responsible for building family-driven, sustainable systems of health services and supports for children and youth with special needs. Through interagency collaboration, the program connects families to culturally respectful, community-based resources. There are now 14 county-level offices statewide that assist families in obtaining needed care and services.

The Colorado Medical Home Initiative promotes a team-based approach to providing health care. Children and youth with special health care needs may have many professionals invested in their physical and emotional well-being. Coordination of care is an essential activity to assure communication and planning among team members, including family, primary health care practitioners, specialists, community programs, and insurance plans.

Colorado Responds to Children with Special Needs (CRCSN) is Colorado's birth defects monitoring and prevention program. CRCSN maintains a database with information about young children with birth defects, developmental disabilities, and risks for developmental delay. The program provides data to other programs, agencies, and researchers. CRCSN and HCP share data so that HCP can link children and families, who have been identified with birth defects and related disabilities, with early intervention services through the HCP CRSCN Notification program.

The Diagnostic and Evaluation (D&E) Program, also called the Diagnostic and Evaluation Clinics, provides access to comprehensive, multidisciplinary, developmental evaluation services for children who have or are suspected of having a developmental delay or disability. The program provides the needed medical diagnosis for many children who do not have access to a developmental pediatrician. It is community-based and coordinated with the Colorado Department of Education's Child Find and other local specialty providers. To ensure that D&E clinics are part of a child's medical home, training and consultation are provided to primary care physicians.

The Colorado State Genetics Program works to protect and improve the health of all Coloradans by promoting the availability of high quality, comprehensive genetic diagnostic, counseling, screening, treatment, and referral services.

The Newborn Screening Program provides screening at birth and again at 8 to 14 days of age for a variety of metabolic and genetic diseases for all infants born in the state. Presumptive positive screens are followed annually to make sure that affected infants are diagnosed and receive timely referral and treatment.

The Infant Hearing Program tests the hearing of infants at birth and identifies deaf and hearing-impaired infants and makes appropriate referrals. To support the program, a Colorado Infant Hearing Advisory Committee was formed, comprised of parents, consumers, public health professionals, physicians, and other stakeholder state agencies. The advisory committee is very active, meeting quarterly, and supporting a variety of specific task forces that address issues and develop additional guidelines.

In Colorado, blind and disabled individuals under the age of 16 receive rehabilitation services under Title XVI (SSI). All SSI beneficiaries under 16 years of age are automatically eligible for Medicaid. Community-based EPSDT outreach workers call all newly enrolled SSI beneficiaries to assess whether each child's medical and support needs are being met. In the majority of cases, Medicaid is covering all of the medical needs. Staff of the Health Care Program for Children with Special Needs in the local health departments become involved when families have more complex medical or psychosocial needs needing care coordination.

In another effort, a durable medical equipment loaner bank is being developed. The state HCP occupational therapy/physical therapy consultant is building a statewide coordinated network to facilitate the development and expansion of a voluntary bank. Occupational and physical therapy coordinators have surveyed their regions for both the existence of and the need for loaner systems. A statewide Web site is planned for FY 2006 that will list inventory and conditions for accessing inventory. Parents and professionals will be able to list and locate inventory for use by a child or family.

The durable medical equipment loaner bank will be completely voluntary for all parties; none will incur responsibility as to the condition or fitting of equipment. Regional coordinators will be available to assist facilities or programs with the Web site and with initial inventory identification

and entry. HCP staff plan to use volunteers, including high school and college students, in the effort to identify and inventory equipment. Satisfaction surveys will be used to measure the success of the system.

Family-centered, community-based, coordinated care including care coordination is another responsibility of the HCP program, which is engaged in a public education campaign to assure that all families of children with special health care needs know about the services that are available to them. This campaign also targets health care providers and partner agencies.

/2007/ A variety of updates regarding children and youth with special health care needs are provided in Section III B and Section IV C. //2007//

/2008/ The program's state and community level multi-disciplinary teams continued to move from a clinical-oriented system to one focused on medical home, screening and local health care systems of care development. This public health approach will assist the Unit in streamlining efforts to address needs given limited resources.

The CSHCN integrated data system was further developed. It has two applications 1) Newborn Evaluation, Screening and Tracking (NEST) and 2) Clinical Health Information and Records for Patients (CHIRP). The electronic newborn hearing screening system is now available and the newborn metabolic screening system will be available soon. The next steps include integration of the brain injury surveillance data.

An MCH grant that funded the state genetics program ended in March. The Metabolic Screening and Follow-Up Program received funding to develop a new state genetics plan that incorporated MCHand other areas.

A variety of updates regarding children and youth with special health care needs are provided in Section III B and Section IV C. //2008//

/2009/A variety of updates regarding children and youth with special health care needs are provided in Section III B and Section IV C. //2009//

4. Culturally Competent Care that is Appropriate to the State's MCH Population
In 2005, the Office of Health Disparities was established within the department, taking the place of the Turning Point Initiative. A Citizen's Commission on Minority Health was also initiated to coordinate the department's efforts in working with underserved communities.

2007/The department's Office of Health Disparities received an infusion of state funding. The Colorado General Assembly recognized that although Colorado as a whole is a healthy state, racial and ethnic minorities are disproportionately impacted by disease, injury, disability, and death. The Health Disparities Grant Program began distributing funds this year. The purpose of this grant program is to provide financial support for statewide initiatives that address prevention, early detection, and treatment of cancer and cardiovascular disease including diabetes or other precursors and pulmonary diseases in under represented populations. A total of $1,333,669 million was awarded for Fiscal Year 2005-2006. //2007//

/2008/ No changes to this area.//2008//

/2009/The CSHCN Unit working with the Colorado Developmental Disabilities Council will hold a conference on cultural competency in October 2008. The speakers are from the National Center for Cultural Competency at Georgetown University.//2009//

Other Programs Supported by MCH funds

Child and maternal mortality reviews are done by a multi-disciplinary team working together to determine the underlying causes of maternal and child deaths. The reviews also promote preventive programs that may help reduce premature death. Multiple agencies and department programs are involved in both reviews.

The Family Healthline is the statewide MCH information and referral service. The Healthline resource specialist assists women, families, and individuals in locating free or low-cost health care services. Information is provided about other programs such as emergency shelters, food subsidies, or mental health. The Healthline specialists speak fluent Spanish and English. Special arrangements are made for hearing-impared individuals.

2009/ For an update on these programs see Other Program Activities in Section 1V, part F.//2009//

An attachment is included in this section.

C. Organizational Structure

The Colorado Department of Public Health and Environment is one of sixteen Colorado state agencies that are all located in Denver. Douglas Benevento, JD is the Executive Director, and reports to Governor Bill Owens. A CDPHE organization chart is posted at http://10.1.0.61/ic/orgchart.pdf.

CDPHE consists of ten divisions. The Prevention Services Division is responsible for administering the MCH Block Grant, and the Division Director is Jillian Jacobellis, PhD. The Division administers eight sections: Nutrition Services; Chronic Disease; State Tobacco Education and Prevention Partnership; Oral, Rural and Primary Care; Women's Health; Child, Adolescent, and School Health; Children and Youth with Special Health Care Needs; and Injury and Suicide Prevention. The division houses a wealth of talent and resources relevant to women's and children's health, as well as expertise in health promotion and disease prevention. A division organizational chart is attached to this section.

/2007/ The Executive Director of the Colorado Department of Public Health and Environment is Dennis Ellis, who reports to Governor Bill Owens. //2007//

/2008/ A new governor, Bill Ritter assumed office in January 2007. The Governor appointed James Martin, an environmental attorney as the new Executive Director of the Colorado Department of Public Health and Environment. The new Lieutenant Governor Barbara O'Brien has a strong interest in the health of children and is expected to provide leadership in this area.

The Prevention Services Division (PSD), where MCH is housed, was re-designed in 2007. The redesign was driven by four internal reports, identifying strategic recommendations that, if implemented, would improve the capacity of the PSD to meet its critical public health responsibilities. The Division adopted the following goal to guide the redesign effort. "The Prevention Services Division is positioned to be a public health leader in producing healthy outcomes and reducing preventable death and disability by implementing best processes and practices that emphasize integrative, crosscutting approaches among prevention programs." Aligning structure and functions within the Division will be a critical component of realizing this vision.

The Division was divided into two Centers: The Center for Healthy Living & Chronic Disease Prevention and the Center for Healthy Families and Communities, along with an Office of Policy, Fiscal Analysis and Operations and a cross-divisional Epidemiology, Planning and Evaluation Unit. Two additional cross-divisional Training and Grants Management Units will be established in the coming year.

The Center for Healthy Families and Communities houses all MCH activities and is directed by Karen Trierweiler, MS, CNM, formerly the Director of the Office of Maternal and Child Health. Ms. Trierweiler also retains the role of MCH Director.

The Center for Healthy Families and Communities includes the Special Supplemental Nutrition Program for Women, Infants and Children; the Child and Adult Care Food Program housed with WIC; the Women's Health Unit (Family Planning, Prenatal, Prenatal Plus and Nurse Home Visitor Programs); the Child, Adolescent & School Health Unit (Early Childhood Systems Development, Adolescent Health Program, School-Based Health Centers, Coordinated School Health Program and the Tony Grampsas Youth Services Program); the Children with Special Health Care Needs Unit; the Injury, Suicide and Violence Prevention Unit; and the Center's Fiscal and Administrative Services Unit.

The Center for Healthy Living and Chronic Disease Prevention includes the Chronic Disease Prevention Branch (Diabetes; Cardiovascular Disease; Asthma; Comprehensive Cancer Program; Breast & Cervical Cancer Program, (Colorado Women's Cancer Control Initiative); the Oral Health Unit; the Healthy Living Branch that includes the Healthy Aging Unit, State Tobacco Education and Prevention Partnership, Colorado Obesity, Physical Activity and Nutrition Unit; and a Center-specific fiscal and administrative services Unit.

The Office of Policy, Fiscal Analysis and Operations includes the Interagency Prevention Systems for Children and Youth, which contains the Inter-Departmental Prevention Leadership Council; the Primary Care Office; and provides coordination of the Division's overall fiscal policy and human resources functions.

Reorganization of the Division has resulted in changes at the program level. Some staff have been moved from positions associated with specific programs to cross-divisional Units. For example, data and evaluation staff no longer report to the director of a particular program, but work together in the Epidemiology, Planning and Evaluation unit. As a result, program managers have access to a specific work unit composed of staff with a variety of skills in data and evaluation.

An updated organizational chart is attached to this section. //2008//

/2009/The Epidemiology, Planning, and Evaluation (EPE) Branch was operational. The Branch works collaboratively with programs in the Prevention Services Division and other partners to conduct systematic collection, analysis and interpretation of population-based and program-specific health and related data in order to assess the distribution and determinants of the health status and needs of the population, for the purpose of planning and implementing effective interventions, promoting policy development, and evaluating the outcome of these activities. The Branch provides accurate, timely, and valuable information and services that meet the needs of its partners.

An updated organizational chart is attached to this section.//2009//

D. Other MCH Capacity

Title V funds and matching state funds pay for 47.7 FTE almost exclusively housed at the Colorado Department of Public Health and Environment in Denver.

The Office of Maternal and Child Health is directed by Joan Eden, RD, MS, and is composed of four units. A fiscal and contracts management section is led by Sally Merrow. The SSDI Coordinator, Jan Reimer, works with the MCH Epidemiologist, Bill Letson, MD, and a statistical analyst. Geoff Bock manages the MCH Data Services unit. Sue Ricketts, PhD is the MCH Demographer and is assisted by a statistical analyst.

Senior staff associated with MCH-priority area sections are Karen Trierweiler CNM, MS, Director of the Women's Health Section, Barbara Ritchen, RN, MS, Director of the Child, Adolescent, and School Health Section; and Kathy Watters, MA, Director of the Children and Youth with Special Health Care Needs Section. Organizational charts for the Office of Maternal and Child Health and the Prevention Services Division are attached.

There is one paid FTE family consultant within the Health Care Program for Children with Special Health Care Needs at the state health department in Denver. Each of the regional offices associated with the program has a family consultant.

Brief Biographical Information for Key MCH Management Staff

Joan Eden, RD, MS
Director of the Office of Maternal and Child Health and
Deputy Director of the Prevention Services Division

Joan Eden has a Master of Science Degree in Public Health and Nutrition from Columbia University. She is also a Registered Dietitian. Before coming to Colorado, she worked in New York City in a Maternal Infant Care Project as a clinical nutritionist. She has been with the state health department for 27 years working with the Migrant Health Program, the Prenatal Program, and the Child Health Program as a Nutrition Consultant. She served as the state's Children with Special Health Care Needs Director for eight years before becoming the state's Maternal and Child Health Director in October of 2000. She also serves as the Deputy Director of the Prevention Services Division.

Bill Letson MD, MS FAAP
Pediatric Consultant/Maternal Child Health Epidemiologist

Dr. Letson is trained in Pediatrics, Infectious Diseases and Public Health Epidemiology. He is from a Colorado Western Slope pioneer family and received his medical education at the University of Colorado. Dr. Letson's Pediatric and Chief Residency was completed at the University of Arizona. He completed a Pediatric Infectious Diseases fellowship at Johns Hopkins University, and additional Public Health Training at the Centers for Disease Control and Prevention, including a fellowship in Maternal Child Health Epidemiology. In addition to working for eight years on vaccine studies with CDC at Indian Health Service sites, Dr. Letson has practiced community pediatrics at clinics for uninsured children. He was also MCH director and Chief Medical Officer for the state of Wyoming.

Jan Reimer, BA
Coordinator, MCH State Systems Development Initiative (SSDI)

Jan Reimer has been the MCH State Systems Development Initiative Coordinator since 1993. Prior to this position she was the Coordinator of the Refugee Health Care Access Program for the State Health Department. Ms. Reimer was educated at Macalester College in St. Paul, Minnesota and holds a Bachelors of Arts in Sociology.

Sue Ricketts, M.A., PhD
Maternal and Child Health Demographer

Dr. Ricketts has been at the Colorado Department of Public Health and Environment for more than 20 years. She has long been involved in public health research in maternal and child health, particularly issues related to teen fertility, prenatal care, and low birth weight. Dr. Ricketts began her career at the Population Council in New York City, and came to Colorado to work at the

former U.S. Department of Health, Education, and Welfare. She has also worked at the national Education Commission of the States in Denver and taught at Colorado Women's College and the University of Colorado at Denver. She holds an undergraduate degree in Economics from Wellesley College, and an M.A. and Ph.D. in Demography from the University of Pennsylvania.

Barbara Ritchen, RN, MA
Director, Child, Adolescent and School Health Section

Barbara Ritchen has been with the Colorado Department of Public Health and Environment since 1985, first as Director of the Adolescent Health Program, then of the Child, Adolescent and School Health Section. During that time she also directed a national center, funded by the federal Maternal and Child Health Bureau, to promote adolescent health leadership and to provide training and technical assistance to state MCH programs across the country. Her areas of expertise include child, adolescent and school health; training; team development; facilitation; leadership; health education and health promotion; community development; needs assessment and strategic planning. Barbara's background includes a Bachelor of Science in Nursing from the University of Texas and a Master's Degree in Health Education from the University of Northern Colorado.

Karen Trierweiler, CNM, MS
Director Women's Health Section

Karen Trierweiler is a certified nurse midwife with over 25 years of experience in women's health as a clinician, educator, and public health professional. She received both her undergraduate and Master's degrees in Nursing from the University of Colorado. Ms. Trierweiler has worked at the Colorado Department of Public Health and Environment since 1990, originally as a nurse consultant, and since 2000, as the Director of the Women's Health Section.

Kathy Watters, MA
Director Children and Youth with Special Health Care Needs Section

Kathy Watters came to the Colorado Department of Public Health in 1984 from the Colorado Department of Education's State School for the Deaf and Blind. She received her undergraduate degree in Communication Disorders from the University of Cincinnati and her Master's degree in Audiology from the University of Colorado-Boulder. Kathy began her career at the state health department as the Home Intervention Program Director. She subsequently became the Hearing and Speech Director, the Consultation Team Director, the HCP Assistant Director, and the HCP Director. She is now the Section Director for Children and Youth with Special Health Care Needs.

MCH funds are distributed to local contractors (primarily health departments and nursing services) via a formal planning process. Based on the state-defined MCH priorities, contractors are asked to assess and prioritize the local health status needs of the perinatal, child and adolescent, and children with special health care needs populations; and to identify how their allocated MCH funds will be used. The services or activities they implement are expected to address the ten Colorado MCH priority areas.

The state-level MCH program assists agencies by providing consultation and technical assistance in developing and carrying out plans. Also, state-prepared model plans associated with priority areas are available. The plans consist of already developed goals, objectives, activities, process evaluation methods and outcome evaluation methods. Agencies can choose to implement one of these model plans or they may develop their own workplan. More information about the MCH

planning process and forms are at www.cdphe.state.co.us/ps/mch/plan/forms.html.

/2007/Several changes have occurred among senior staff. Joan Eden retired and Karen Trierweiler is the new Director of the Office of Maternal and Child Health. Ms. Trierweiler was the Director of the Women's Health Section, and the acting director of that section is now Ms. Candace Grosz. Jan Reimer retired and the SSDI Coordinator is Helene Kent. Sue Ricketts, MCH Demographer, will be taking a phased in retirement and is working part-time.

Candace Grosz is Acting Director for Women's Health Section and the Program Manager for Prenatal Programs. She is a Licensed Clinical Social Worker (LCSW) with a master's degree in Social Work and previous experience in child abuse and neglect services, victim services and grants management. She currently provides supervision of prenatal and family planning programs, financial staff, and The Colorado Women's Cancer Control Initiative, and is also the program director for the Title X family planning program.

Helene Kent RD, MPH is the MCH Planning and Evaluation Specialist and will function as the SSDI Coordinator. She has over 14 years of experience with the Colorado Department of Public Health and Environment, including previous tenure as the Director of the Women's Health Section within the Office of MCH. Ms. Kent was the Director of Assessment and Assurance for the Association of Maternal and Child Health in Washington DC.

An updated organizational chart is attached to this section. //2007//

/2008/Candace Grosz was appointed the Director of the Women's Health Unit.

Barbara Ritchen retired as the Director of the Children, Adolescent and School Health Section Unit.

Rachel Hutson has been appointed as the new Director of the Child, Adolescent and School Health Unit.

Ms. Hutson has been with the Colorado Department of Public Health and Environment since 2001, as the Director of Early Childhood Initiatives. She now provides supervision and oversight for Smart Start Colorado, the Coordinated School Health Program, the School-Based Health Center Program, the Child Health Program, Adolescent Health Program, and the Tony Grampsas Youth Services Program. Prior to working for the department she was the Pediatric Health Services Coordinator at the Colorado Coalition for the Homeless, where she provided primary health care services as a Pediatric Nurse Practitioner at the Stout Street Clinic in Denver. Ms. Hutsen received a BA from Franklin and Marshall College and a Masters in Nursing from Yale University.

Bill Letson, MD left the Office of Maternal and Child Health.

Sally Merrow retired as the fiscal officer and has been replaced by Laurie Borgers.

An updated organizational chart is attached to this section. //2008//

/2009/
Gabriel Kaplan, M.P.A, Ph.D., is the branch director of Epidemiology, Planning and Evaluation. Dr. Kaplan recently joined the Department of Public Health and Environment after spending the last 5 years as an assistant professor of public policy at the University of Colorado, Denver School of Public Affairs. Dr. Kaplan received his Ph.D. in public policy from Harvard University in 2002 and his Masters in Public Affairs from Princeton University in 1994. He has worked as an analyst for the US Senate, for government agencies overseas, and nonprofit clients.

Laurie Freedle is the new fiscal officer.

Barbara Gabella is Epidemiolgy & Surveillance Director for the Epidemiology, Planning and Evaluation Branch.

Shirley Babler is the new Health Care Program for Special Needs Director with in the Children with Special Health Care Needs Unit. //2009//

E. State Agency Coordination

Relationships among the State Human Service Agencies
MCH staff work with other state agency staff on a daily basis through numerous coalitions, task forces, advisory groups, committees, and cooperative agreements. The following text briefly describes a few key relationships.

An Interagency Prevention Council has existed for many years, and in 2000 was mandated through statute. The Council has created a more unified, effective and efficient approach to the delivery of state and federally-funded prevention, intervention and treatment services for children and youth in Colorado. More information can be found at www.cdphe.state.co.us/ps/ipsp.

The Colorado Department of Education is a close partner of the Title V program in supporting the coordinated school health model, school nurses across the state, and school-based health center activities. MCH has partnered with the Department of Education to support school health education, statewide conferences, adolescent health training, the Youth Risk Behavior Survey, and the Adolescent Health in Colorado Report.

The Colorado Department of Health Care Policy and Financing houses the Medicaid and children's health insurance plan for the state. The agencies work together to improve the health of Medicaid-eligible women and children and on issues such as EPSDT, lead poisoning, family planning, immunizations, birth defects, Prenatal Plus, and oral health.

The Colorado Department of Human Services (in particular the Division of Developmental Disabilities) is a close partner of Title V. There are ongoing interactions in the provision of services for the many children served by the Health Care Program for Children with Special Needs, children who are also eligible for services through the Colorado Department of Human Services. Programs include Early Intervention Services for child development for infants and toddlers birth to age three; Family Support Services Program for families who maintain a family member with developmental disabilities in the family home (all ages); Children's Extensive Support Waiver for children birth to 18 who are considered to be the most at-risk for out-of-home placement due to the severity of their needs; and the Children's Medical Waiver for children age birth to 18 with developmental disabilities that allows access to Medicaid state plan benefits for children who would otherwise be ineligible due to parental income. The state health department works closely with the Alcohol and Drug Abuse Division to plan coordinated workforce development and joint training and technical assistance. Other partners include the Division of Youth Corrections, the Mental Health Division, the Child Care Division, and the Child Protective Services Division.

Relationships with Federally Qualified Health Centers and Primary Care
The Colorado Community Health Network (CCHN) is the state primary care association representing 15 community, migrant, school-based, public housing, and homeless centers operating 108 health care delivery sites. Colorado's community health centers provide over 1.5 million visits to over 392,000 low-income patients each year, many of them women and children.

Community health centers are the medical home for an estimated 28 percent of Colorado's low-income, uninsured population, 34 percent of Child Health Plan Plus enrollees, and 28 percent of Medicaid enrollees.

The Rural and Primary Care Office within the Oral, Rural and Primary Care Section works with CCHN to improve accessibility and expand primary care services to targeted low-income and vulnerable populations. These efforts include information and data sharing; recruitment and retention of health professionals; policy development; and assisting communities with applying for health professional shortage area and medically underserved designations.

Relationships with Local Public Health Agencies

The MCH program works through the state health department's Office of Local Liaison to address MCH issues in the 39 counties with local nursing agencies. The MCH program works directly with the 15 organized health departments that serve the 25 largest counties in the state. MCH funds are distributed to local health agencies to assess the MCH population needs in their communities and to address priorities.

Relationships with Tertiary Care Facilities

MCH has a good working relationship with Denver Health, the largest community health system in the country. Denver Health includes Denver Health Medical Center, community health centers, school-based health centers, and the public health department for the city and county of Denver. The MCH program also works closely with The Children's Hospital, the state's only hospital for children. The Health Care Program for Children with Special Needs funds a position at the hospital to coordinate the inpatient and outpatient services provided through the hospital with those services needed and provided in the community.

Available Technical Resources

The Department of Preventive Medicine at the University of Colorado at Denver and Health Sciences Center provide technical resources to MCH programs. JFK Partners, a joint program between the Departments of Pediatrics and Psychiatry, is also another valuable resource. JFK Partners is the Leadership Enhancement in Neurological Disabilities grantee and focuses on children with developmental disabilities and special health care needs. The University of Colorado at Denver and Health Sciences Center School of Nursing and the Center for Human Investment Policy at the University of Denver also provide technical assistance on conducting community needs assessments; and provide legislative, policy, and research updates.

The Colorado Regional Institute for Health and Environmental Leadership housed at the University of Denver provides an Advanced Leadership Training Program for public health staff.

Colorado actively participates with other Title V directors and staff in planning initiatives associated with the MCHB-funded Rocky Mountain Public Health Education Consortium. Title V also encourages the participation of state and local-level MCH staff in the Rocky Mountain Public Health Education Consortium products such as the Summer Institute in Maternal and Child Health in Salt Lake City, the MCH Certificate program, and available distance learning courses.

Title V Program Coordination with other Specific Programs

The MCH Program works with many other programs within and external to the state health department. The following list is incomplete, but includes some programs not funded by Colorado Title V or other federal programs.

The Aurora Healthy Start Initiative is located in the city of Aurora, adjacent to Denver. The program developed in response to exceptionally high infant mortality in two zip code areas. MCH

assists by providing demographic and health risk information for the two zip code areas, and by sharing materials and resources.

The Colorado Breastfeeding Task Force is a volunteer organization that works to ensure optimal health and development of mother infant bonding by increasing Colorado breastfeeding rates, particularly among underserved populations.

The Colorado Perinatal Care Council is a statewide organization of perinatal care providers. The Council's major focus is the coordination and improvement of perinatal care services in Colorado. The state health department provides space and support for the Council, which is co-located with the MCH program. The Council is a volunteer, non-profit, advisory group whose members include obstetricians, pediatricians, perinatologists, social workers, neonatologists, and nurse practitioners.

Colorado Covering Kids & Families (CKF) is a coalition-based project aimed at reducing the number of uninsured children. CKF has a membership of over 200 community-based organizations, agencies, and individuals. Through outreach efforts, CKF works to ensure that all eligible children and adults are enrolled in public health insurance programs.

The Folic Acid Task Force works to design and implement programs that will increase folic acid consumption among Colorado women by means such as targeted social marketing campaigns.

Healthy Child Care Colorado's goal is to provide safe and healthy child care environments; to increase accessibility to immunizations; and to provide access to quality health, dental, and developmental screenings and follow-up by supporting a network of child care health consultants. The initiative is an educational resource for center and family child care providers throughout the state. The project was previously funded through the Maternal and Child Health Bureau as part of the Healthy Child Care America initiative. When the funding ended in January 2005, the Child, Adolescent and School Health Section agreed to continue supporting the project through the MCH Block Grant.

Oral Health Awareness Colorado (OHAC!) is the statewide oral health coalition. The coalition has two primary goals: to maintain a media campaign ("Be a Smart Mouth"), and to develop a state oral health plan. The coalition is in the process of developing a statewide oral health improvement plan. The web address is www.beasmartmouth.com.

The State Tobacco Education and Prevention Partnership is funded from the state tobacco master settlement agreement monies. Goals include decreasing youth tobacco initiation; promoting quitting of tobacco among youth and adults; and reducing exposure to environmental tobacco smoke.

The Tony Grampsas Youth Services is a statutory program housed in the Child and Adolescent School Health Section. It provides funding to local organizations that target youth and their families with programs designed to reduce youth crime and violence. The program also focuses on funding programs that prevent or reduce child abuse and neglect.

/2007/The state health department's Child, Adolescent, and School Health Section, Colorado Physical Activity and Nutrition (COPAN) Program, and the WIC Program worked collaboratively with the Healthy Child Care Colorado Project, the Coordinated School Health Program, the Colorado Department of Education, and other interested state and local agencies and organizations in the past year. Together, they developed strategic state and local action steps to address the issue of overweight and obesity among children and adolescents. They have initiated an effort that will allow measurement of the heights and weights of children in kindergarten, first, second, third, seventh, and ninth grades in 50 randomly selected schools throughout the state. A similar collaboration is underway between COPAN and the Title X Family Planning Program. Clients have their BMI's assessed and receive appropriate weight

management messages.

The state health department's Children and Youth with Special Health Care Needs Section is a co-sponsor with the Diabetes Program and the Child, Adolescent and School Health Section in establishing a Regional Diabetes Resource Nurse Program, along with the Colorado Department of Education, the Colorado Diabetes Advisory Council, and the Barbara Davis Center. The purpose of the program is to provide expert consultation to school nurses and school administration in all areas of the state about diabetes-related issues to insure optimal, standardized, and coordinated care for students with diabetes. The proposal, funding, training, and evaluation of the program were developed this year.

The Colorado Departments of Transportation; Revenue, Motor Vehicle Division; and Public Safety, State Patrol are key partners in new efforts to address teen motor vehicle safety.

The Colorado Department of Education works closely with early childhood state systems building efforts.

The Children, Adolescent and School Health Section, Nurse-Family Partnership Program is working with the Colorado Department of Health Care Policy and Financing to secure Medicaid reimbursement for targeted case management services, which will lead to an increase in the number of clients served.

The Colorado Department of Human Services, Alcohol and Drug Abuse Division works with the health department to develop a common Web based reporting and evaluation system for local grantees. //2007//

/2008/MCH funded programs continued to work closely with other partners to carry out activities. The Women's Health Unit has worked with the Diabetes Program and the state tobacco control program to initiate projects of joint interest. The Children and Youth with Special Health Care Needs and the Child, Adolescent, and School Health Units continue to work with many partners to carry out their respective work. Many staff are active members on committees and taskforces that have been convened to address common issues. Additional information regarding these activities ispresented through out this application. //2008//

Title V Program Coordination with Other Specific Programs
1. Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)
In 2003 after over 20 years of being responsible for case management and outreach portions of the Colorado EPSDT program, the state health department ceased administration of the program. The Medicaid Program now contracts directly with local health agencies. However, Health Care Program for Children with Special Needs local and regional care coordinators work with EPSDT staff on a daily basis. In almost every county health agency, the EPSDT coordinators work with other public health service programs such as WIC, prenatal, child health programs, immunization services, and the Health Care Program for Children with Special Needs. At the state level, Title V continues to work with EPSDT and to participate in the EPSDT State Advisory Board. EPSDT staff also serve on the Health Care Program for Children with Special Needs Medical Home Advisory Committee.

2. Other Federal Grant Programs
The WIC Program resides in the same division as the Office of Maternal and Child Health. Joint efforts for improving certain MCH performance measures have been in place for years. Current efforts are focused on increasing immunization and breastfeeding rates and decreasing childhood overweight. WIC funds go to all of the local health agencies.

Colorado is one of nineteen states that have received a CDC Coordinated School Health

Program grant. The project's purpose is to build partnerships and an integrated, sustainable system that directly supports the missions of both the Colorado Department of Education and the Colorado Department of Public Health and Environment. Expected results are improved academic and health outcomes for Colorado school-aged children and youth.

An Early Childhood Comprehensive Systems Building grant is funded by the Maternal and Child Health Bureau. The initiative began in 2003 with a focus on creating a strategic plan to support a comprehensive early childhood system, which includes health, mental health, early care and education, family support and parent education. There are currently eight task forces working on the goal areas of Colorado's strategic plan: Program Quality and Standards, Program Availability, Finance, Organizational Structure, Policy, Public Engagement, Parent and Family Engagement and Outcome and Evaluation. The two-year strategic planning grant ended June 30, 2005 and implementation funding through the Maternal and Child Health Bureau is anticipated in the fall of 2005.

Title X Family Planning is housed within the Women's Health Section, which also administers the prenatal component of the MCH Block Grant. The MCH Block grant and Title X family planning activities are well-integrated. Activities to address unintended pregnancy and teen fertility are targeted to both family planning and MCH contractors. MCH funds are not used to fund direct family planning services, but rather to support population-based activities around family planning and unintended pregnancy prevention.

The Child and Adult Care Food Program is a USDA funded program that provides reimbursement for nutritious meals and snacks served to eligible children in child care centers, family day care homes, and eligible adults in adult care centers. Work has been coordinated regarding healthy child care initiatives.

The Colorado Physical Activity and Nutrition Program (COPAN) is funded by CDC. The program developed and is implementing the Colorado Physical Activity and Nutrition State Plan 2010. The plan promotes healthy eating and physical activity to successfully prevent and reduce overweight, obesity, and related chronic diseases. MCH staff serve on the early childhood and school site task forces, planning joint videoconferences and tool kits.

Early Hearing Detection and Intervention (EHDI) is funded by a CDC grant. The grant allows for the integration of a variety of databases beginning with the universal newborn metabolic screening and infant hearing screening data. It will include the Birth Defects Monitoring Program, an immunization registry, and asthma surveillance data. Clinical databases have been created for Sickle Cell Disease, the Inherited Metabolic Diseases, and infant hearing loss. Work has begun on the central processing database and its linkage to the recently created databases and the Integrated Registration and Information System (IRIS). Also underway is the implementation of the CHIRP/NEST (Clinical Health Information Record of Patients/ Newborn Evaluation Screening and Tracking) applications.

Violence reduction efforts are funded by CDC. Colorado is one of eight states to receive CDC funding for a two-year program that will work to support change in societal norms and environmental conditions contributing to violence. A strategic plan is being developed that addresses shared risk and protective factors for violence among children and youth.

/2007/Colorado received a grant from the Maternal and Child Health Bureau, State Agency Partnerships for Promoting Child and Adolescent Mental Health, referred to as Colorado LINKS (Linking Interagency Networks for Kids' Services) for Mental Health. The mission of this initiative is to promote partnerships among state agencies and key stakeholder organizations by weaving together existing efforts to create a more coordinated continuum of mental health services for Colorado children, youth, and families.

Colorado received a $2,350,965 grant from the Substance Abuse and Mental Health Services

Administration to advance community-based programs for substance abuse prevention, mental health promotion and mental illness prevention. The program, which is housed in the Alcohol and Drug Abuse Division (ADAD) at the Colorado Department of Human Services, is a collaborative effort between ADAD and the statewide Prevention Leadership Council. The purpose of this "Colorado Prevention Partners" grant is to build capacity and infrastructure at the state and community levels, reduce substance abuse-related problems in communities, and prevent the onset and reduce the progression of substance abuse, including underage drinking. The grant will bring together multiple funding streams from multiple sources in Colorado to implement a comprehensive approach to prevention that cuts across existing programs and systems.

Early Childhood Comprehensive Systems Building grant staff completed a two-year strategic planning process and received implementation funding from the Maternal and Child Health Bureau.

Colorado is one of two to receive CDC funding for implementation of a strategic plan that addresses shared risk and protective factors for violence among children and youth. //2007//

/2008/No new grants were received this year. //2008//

/2009/ The Maternal and Child Health Integrated Systems for Children with Special Health Care Needs (CSHCN) proposal was selected for funding. The grant will support the goals of the Colorado Medical Home Initiative.

The MCH Early Hearing Detection and Intervention (EHDI) grant was awarded in March. This grant continues to support the Colorado Medical Home Initiative by ensuring the integration of the newborn hearing screening into medical home systems.

A CDC EHDI grant was award to integrated EHDI information technology systems with the states' immunization registry and Colorado's Early Intervention data system in the Department of Human Services.

The Women's Health Unit received a large grant from a private foundation to expand family planning services.//2009//

3. Providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in applying for other services.
The majority of local MCH contractors also served as presumptive eligibility sites for Medicaid. The Baby Care/Kids Care Program (authorized under Colorado's Medicaid state plan) allowed Medicaid presumptive eligibility determinations to be made at public health sites. MCH contractors identified women and infants who were eligible for Medicaid at the local public health site (through WIC, family planning, EPSDT, etc.), and deemed them presumptively eligible for Medicaid if the income requirements were met. With the elimination of the presumptive eligibility program, local sites are now assisting clients in completing Medicaid applications and working with both state and local social service providers to expedite eligibility determinations. Women are then referred to community resources for direct care, case management, and other services. Eligibility determinations are also made for Child Health Plan Plus in many of these same sites. Presumptive eligibility determination is expected to be reinstated in the coming year.

4. Title V Coordination with the Social Security Administration, State Disabilities Determination Services unit, Vocational Rehabilitation, and Family Leadership and Support Programs
Social Security Administration (SSA)

Relationships with the State Determination Unit of the Social Security Administration are strong. Local level EPSDT outreach workers make calls to families of children receiving SSI to assess

whether service and support needs are being met. Referrals are made to the Health Care Program for Children with Special Needs when family needs are complex and the EPSDT outreach worker feels that care coordination by a Health Care Program for Children with Special Needs staff member is appropriate.

Developmental Disabilities
This area was addressed in the Colorado Department of Human Services section under Relationships among the State Human Services Agencies.

Vocational Rehabilitation
Relationships with Vocational Rehabilitation have been cultivated through the Colorado Interagency Transition Team. This team of ten stakeholders collaboratively addresses the topic of youth transition to adulthood for the state of Colorado. In 2005, the state health department was invited to participate on the team with HCP as the representative. Also, a representative from Vocational Rehabilitation sits on the Colorado Health Transition Coalition, initiated and led by HCP. Both the Department of Education's Special Education Section and Vocational Rehabilitation are actively involved in the Brain Injury Steering Committee and a task force on Assistive Technology.

Family Leadership and Support
Title V has supported Family Voices Colorado financially and through membership on its board of directors since it became an official chapter in 2001. Family Voices is involved in the Medical Home Learning Collaborative. Family Voices also works with the state-level Children and Youth with Special Health Care Needs family position and local family consultants to implement the Family-to-Family Health Information Network, and provides state level family advocacy. The Health Care Program for Children with Special Needs has also financially supported the Colorado Families for Hands & Voices to engage in family advocacy, outreach to underserved populations, and parent leadership activities in our EHDI systems grant.

A number of examples of state agency coordination have been provided in this section, but this list does not contain every cooperative effort. Other examples are provided in the text in other sections, particularly in the performance measures sections (IV C and IV D).

/2007/ Family Voices also provides the parent perspective in developing systems of care for the Early Childhood State Systems Team. //2007//

/2008/There are no additions to this area at this time. //2008//

/2009/ The Colorado legislature initiated an interim committee, the Behavioral Health Taskforce, for the study of behavioral health and treatment in Colorado. The taskforce, composed of legislators, state agency staff and advocates, was charged with studying mental health and substance abuse services to coordinate state agency efforts, streamline service provision and maximize federal and other funding sources. A number of recommendations were developed by the task force and are available at http://www.csi-policy.org/1050taskforce/index.htm. As a result of this work, Governor Ritter convened a behavioral health cabinet, whose members are currently working on streamlined systems and integrated funding for behavioral health.//2009//

F. Health Systems Capacity Indicators

Introduction

The data for a variety of Health Systems Capacity Indicators for Colorado are shown below, along

with a brief narrative for each topic.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	60.8	63.2	65.9	57.7	53.8
Numerator	1951	2089	2213	2002	1889
Denominator	321040	330533	335973	347145	350943
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

Notes - 2005
Data shown for reporting year 2005 are calendar year 2004 data.

Narrative:
Health System Capacity Indicator 01 shows a variable rate of hospitalization for asthma, ranging between 53.8 per 10,000 children under the age of 5 to 65.9. Data for 2007 (2006 calendar year) show 1889 hospitalizations, resulting in a rate of 53.8, the lowest rate in the five years shown.

The Colorado Child Health Survey, carried out annually, provides a wealth of data on asthma that contributes to an understanding of asthma beyond what hospitalization data can provide. According to the calendar 2006 survey (which pertains to the same time period as the data shown above for reporting year 2007) 12.5 percent of children ages 2 to 14 were diagnosed with asthma. Among this group, 70.3 percent still had asthma, 9.5 percent were hospitalized for asthma at least once in their lifetime, 24.1 percent had been to an emergency room or urgent care center for asthma, and 76.2 percent used a rescue medication. Among those who used a rescue medication, 34.8 percent carried an inhaler to school, and 64.1 percent obtained a refill at least once in the previous six months. Other information on daily medication use, asthma management plans, and the provision of plans to the child's school is also available from the survey.

The Child Health Survey has been in place since 2004. With four years of data now available (2004 through calendar 2007), we can begin to look at trends and begin to have enough surveys to provide data for some large counties. Statewide, the percent of children diagnosed with asthma was 12.4 in 2004, 10.9 in 2005, 12.5 in 2006, and 11.9 in 2007. The year to year changes are not statistically significant and the rate is essentially unchanging.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	88.4	84.2	80.3	94.1	89.6
Numerator	25516	24554	25588	28344	26673
Denominator	28854	29171	31864	30122	29755
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Data are from the HCFA 416 report for federal fiscal year 2007.

Notes - 2006
Data are from the HCFA 416 report for federal fiscal year 2006.

Notes - 2005
Data are from the HCFA 416 report for federal fiscal year 2005.

Narrative:
The percent of Medicaid enrollees under the age of one who received at least one initial period screen has varied considerably in recent years. Data are taken from the Medicaid CMS 416 form, but there appear to have been differences in how the infants were counted in different years, and the series should not be considered to contain consistent values.

The number of infants on Medicaid increased between reporting year 2003 (FY 03 data) and reporting year 2005 (FY 05 data), but declined in reporting year 2006 (FY 06 data) and 2007 (FY 07 data). The introduction of the Colorado Benefits Management System (CBMS) in the fall of 2004 resulted in fewer applications in FY 05 being approved because of problems associated with the new system. In July 2006, new restrictions around required documentation of citizenship may have contributed to a decline in the number of children served in FY 07--a number that is lower than the total served in either of the two previous fiscal years.

The percentage of infants on Medicaid who received at least one initial periodic screen declined between reporting year 2006 and 2007. The reason is not known, but the percentage, 89.6, falls within the range of percentages in other years.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	0	0	0	73.9	0
Numerator				965	
Denominator				1305	
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Data are not available for the period July 2006 through June 2007.

Notes - 2006
Data are for the period July 2005 through June 2006.

Notes - 2005
Data are not available from the state Child Health Plan Plus program for reporting years 2002 through 2005.

Narrative:
For the first time since 2001, data are available for children in the Child Health Plan Plus program for reporting year 2006. The hope was that data would continue to be available. Unfortunately, that has not been the case. Efforts to access the data once again are ongoing.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	66.3	67.1	76.6	76.1	74.0
Numerator	45370	46500	51193	50881	50889
Denominator	68420	69304	66846	66903	68739
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
The data shown for reporting year 2007 are calendar year 2006 data. The denominator is less than the total number of resident births due to missing data needed for the Kotelchuck Index.

Notes - 2006
The data shown for reporting year 2006 are calendar year 2005 data. The denominator is less than the total number of resident births due to missing data needed for the Kotelchuck Index.

Notes - 2005
A change was made this year in how this indicator was measured. The data shown for reporting year 2005 are calendar year 2004 data of the percent of women 15-44 whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. The data reported in previous years was the percentage of women with adequate or adequate plus care according to the Kotelchuck Index.

Narrative:
Data shown for reporting year 2007 are based on calendar year 2006 data. A total of 74.0 percent of women had an observed to expected prenatal visit ratio greater than or equal to 80 percent. This figure is down slightly compared to the value shown for the previous year (74.0 percent). (A change in methodology accounted for the jump between reporting years 2002-2004 to reporting year 2005).

Three out of four Colorado women received an appropriate level of care according to this measure.

Further explanation of the trends in early prenatal care can be found in the discussion in Section IV C, National Performance Measure 18, the percent of infants born to pregnant women who received prenatal care beginning in the first trimester.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	86.6	76.9	95.1	76.0	86.5
Numerator	233467	260497	340929	237200	266888
Denominator	269467	338919	358435	312107	308431
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Date reported in previous years were based on an estimate. Current data reported reflects actual data for calendar year 2006. The numerator is the number of children enrolled in Medicaid vs. the number of potentially Medicaid-eligible children.

Notes - 2006
The number of potentially Medicaid-eligible children who have received a service paid for by the Medicaid program is estimated to be 76.0 percent of all enrolled/eligible children. The estimate is based on a review of all Medicaid utilization data for calendar 2006 for children age 1 through 19. The method for estimating the percentage receiving at least one service is substantially improved from methods used for reporting years 2005 and earlier.

Notes - 2005
The number of potentially Medicaid-eligible children who have received a service paid for by the Medicaid program is estimated to be 95.1 percent of all enrolled/eligible children.

For reporting year 2005, the denominator is composed only of children age 1-20 who are enrolled in Medicaid. In previous reporting years, the number included an additional estimate of children eligible for Medicaid who were not enrolled.

Narrative:

Estimates for this indicator in years 2005 and earlier were based on a variety of data. For the first time, 2006 data are reported directly from Medicaid and are actual counts of children served. Further information is available: for children up to the age of two, 93 percent received a service during the year; for children age 2 through 5, the percent increased to 98; for children 6 through 12, the percent dropped to 77, and for teens age 13 to 19, the percent served was 53.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	50.6	45.3	63.2	49.9	51.5
Numerator	24067	24751	46987	32794	34303
Denominator	47542	54590	74333	65757	66603
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Data are from the HCFA 416 report for federal fiscal year 2007.

Notes - 2006
Data are from the HCFA 416 report for federal fiscal year 2006.

Notes - 2005
Data are from the HCFA 416 report for federal fiscal year 2005.

Narrative:
The percentage of EPSDT eligible children age 6 through 9 who have received any dental services during the year increased sharply between reporting years 2004 and 2005, and then fell in reporting year 2006 (federal fiscal year 2006). There have been changes in how the Centers for Medicare and Medicaid calculate this statistic, but the current value of 49.9 percent is considered to be a more accurate representation of the percent of EPSDT children receiving services than figures prior to 2004.

This health systems capacity measure is Colorado's State Performance Measure 2. For futher explanation of this measure, refer to the discussion in Section IV D of the grant.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	14.0	0.0	0.0	0.0	0.0
Numerator	802	0	0	0	0
Denominator	5727	5741	5940	6133	7495
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Since July 1, 2003, Colorado Children with Special Health Care Needs Program does not directly provide rehabilitative serices to state SSI beneficiaries.

Denominator data are from the Social Security Administration and pertain to 2007. The numerator of zero is correct.

Notes - 2006
Since July 1, 2003, Colorado Children with Special Health Care Needs Program does not directly provide rehabilitative serices to state SSI beneficiaries.

Denominator data are from the Social Security Administration and pertain to 2006.

Notes - 2005
Since July 1, 2003, Colorado Children with Special Health Care Needs Program does not directly provide rehabilitative serices to state SSI beneficiaries.

Denominator data are from the Social Security Administration and pertain to 2005..

Narrative:
The state Children with Special Health Care Needs program stopped paying for rehabilitative services in July 2003. Therefore, 0 percent of state SSI beneficiaries less than 16 years old received rehabilitative services from the program in fiscal year 2006.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2006	other	9.1	7.7	8.2

Notes - 2009
Data are from the 2006 Pregnancy Risk Assessment Monitoring System surveys. No information on Medicaid status is available on birth certificates.

Narrative:
The data shown are from the 2006 Pregnancy Risk Assessment Monitoring System (PRAMS) surveys. Birth certificate data does not include information on Medicaid status, although birth certificate data for 2007 forward will contain this information.

It should be noted that the PRAMS estimate of low birth weight is 8.2 percent, well below the 9.0 percent normally reported based on 2006 birth certificate data.

The percent of LBW infants among Medicaid women shown above (9.1) is 15 percent higher than among non-Medicaid women (7.7).

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2006	other	0	0	0

Notes - 2009
No data are available on infant mortality for births to Medicaid and non-Medicaid mothers. Zeroes have been entered to represent no data.

Narrative:
Infant death data by Medicaid and non-Medicaid status are not available. However, birth certificate data for the year 2007 forward will contain an identifier for Medicaid births. We anticipate that linked birth-infant death files for Medicaid and non-Medicaid infants will become available some time in 2008.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	other	65.7	87.4	79.9

Notes - 2009
Data are from the 2006 Pregnancy Risk Assessment Monitoring System surveys. No information on Medicaid status is available on birth certificates.

Narrative:
The data shown are from the 2006 Pregnancy Risk Assessment Monitoring System (PRAMS) surveys; birth certificate data does not include information on Medicaid status. However, birth certificate data will include Medicaid status beginning with January 2007 births, and the requested information will be available in the future.

Medicaid clients enter prenatal care at much later dates than non-Medicaid patients. Nevertheless, two out of three begin care in the first trimester.

Women who are not on Medicaid access care much earlier. A total of 87.4 percent obtain care in the first trimester, and the Healthy People 2010 goal of 90 percent is nearly met by this group. The challenge for Colorado is clearly among women whose prenatal care is covered by Medicaid. Numerous obstacles exist for early care for this group, including the application process.

This indicator is discussed in detail in Section IV C, National Performance Measures.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	other	65.2	69.1	67.8

Notes - 2009
Data are from the 2006 Pregnancy Risk Assessment Monitoring System surveys. No information on Medicaid status is available on birth certificates.

Narrative:
The data shown are from the 2006 Pregnancy Risk Assessment Monitoring System (PRAMS) surveys; birth certificate data does not include information on Medicaid status. However, birth certificate data will include Medicaid status beginning with January 2007 births, and the requested information will be available in the future.

This measure reveals that just two-thirds of Colorado women receive appropriate care according to the Kotelchuck Index. There is little difference between Medicaid and non-Medicaid women, despite the fact that non-Medicaid women enter care earlier (see HSCI #05C above). This suggests that non-Medicaid women are not receiving an adequate number of visits during pregnancy.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2007	133

INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	205

Notes - 2009
The eligibility level increased from 200 percent of the federal poverty guideline to 205 percent in April 2008.

Narrative:
The percent of poverty level for eligibility for infants in Colorado's Medicaid plan is 133 percent, while the level for infants in the Child Health Plan Plus Program is 205 percent as of April 2008.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2007	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2007	 205 205

Notes - 2009
The eligibility level increased from 200 percent of the federal poverty guideline to 205 percent in April 2008.

Narrative:
Changes in both the Medicaid program and the state Child Health Plan Plus program occurred in 2005. The Medicaid program removed the assets test, which prevented many children from receiving Medicaid benefits. The test had limited a family to $2,000 in assets, although the test did not apply to pregnant women or to children under 1. Removal of the assests tests requirement began in July 2006.

Between July 2006 and December 2006, approximately 3,000 additional children were served each month in the Child Health Plan Plus program because of the increase from 185 percent to 200 percent of poverty.

/2009/
Presumptive eligibility for children in CHP+ and Medicaid was implemented in January 2008. This change provides children and pregnant women at least 45 days and up to 60 days of immediate coverage as they await final eligibility determination.

The 2008 state legislature increased the federal poverty guideline for the Child Health Plan Plus program to 205 percent effective April 2008.

Effective July 2008, the poverty level for determining Medicaid eligibility for children ages 6 to 18 increased from 100 percent to 133 percent of the poverty level.

Effective March 2009, CHP+ eligibility will increase to 225 percent of the poverty level for children.

Further discussion of these changes can be found in Section IV C, National Performance Measure 13. //2009//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2007	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2007	205

Notes - 2009
The eligibility level increased from 200 percent of the federal poverty guideline to 205 percent in April 2008.

Narrative:
Presumptive eligibility for children in CHP+ and Medicaid was implemented in January 2008. This change provides children and pregnant women at least 45 days and up to 60 days of immediate coverage as they await final eligibility determination.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
	1	No

Annual linkage of birth certificates and WIC eligibility files		
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009
Progress is being made to eventually link birth certificate and WIC files.

There has been improvement in the ability of the state health department to obtain Medicaid data from the Colorado Department of Health Care Policy and Financing, although there is not yet linkage of birth certificates and Medicaid eligiblity or paid claims files.

Narrative:
The Prevention Services Division is able to obtain data from most of the data sources listed, and has access to the electronic databases. The Health Statistics Section at the state health department provides much of the data and much of the analysis in addition to the analytical work by Prevention Services Division staff.

However, use of the hospital discharge survey data, other than for injury analysis, is limited. More staff resources are needed to make use of the information that is available.

In addition, birth certificate and Medicaid Eligibility or Paid Claims files are not linked, nor are birth certificates and WIC eligibility files. Work is ongoing with the Colorado Department of Health Care Policy and Financing to obtain Medicaid data Furthermore, the new birth certificate begun in January 2007 allows identification of Medicaid births. In turn, this should result in the ability to link claims data more easily.

The WIC data system is undergoing a large change at this time and the data are not currently linked. It is expected that in the future the files will be linked.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**
Youth Risk Behavior Survey (YRBS)	2	Yes
Colorado Child	3	Yes

Health Survey		

Notes - 2009

The Colorado YRBS has had an adequate sample size to determine statewide estimates in 1995 and 2005. Surveys in 1997, 1999, 2001, and 2003 did not have enough participation to yield statewide estimates. While results are not yet available for the 2007 survey, the number of participants will not be adequate for generalization.

The Colorado Child Health Survey uses Behavioral Risk Factor Surveillance System surveys to determine households with children between the ages of 1 and 14. The parent with the most knowledge about a randomly selected child is then subsequently interviewed. The Survey has been done annually since 2004. An adequate number of surveys each year yields generalizable estimates for a variety of child health indicators.

Narrative:

The Colorado Youth Risk Behavior Survey provides data on adolescent tobacco use every other year.

Child Health Survey data are provided annually. Results are tabulated in the spring of the year following the survey, which is conducted on an on-going monthly basis. Data for 2007 were made available in May 2008. The quick availability of the results greatly enhances program planning.

IV. Priorities, Performance and Program Activities

A. Background and Overview

This section of the grant provides detailed information on Colorado's priorities in maternal and child health. The priorities are addressed through both national and state performance measures. There are a total of 18 national measures and 10 state measures. Each of these is discussed in detail under each measure's heading (Sections IV C and D).

/2007/ No changes were made. //2007//

/2008/ State Performance Measure 4, the rate of birth for Latinas aged 15 to 17 has been discontinued. This is discussed further later in this section. //2008//

/2009/ State Performance Measure 6 Smoking Prior to Pregnancy will be discontinued. The activities associated with this measure are virtually the same as those associated with National Performance Measure 15. Work will continue in this area, but it will be reported for National Performance Measure 15. //2009//

B. State Priorities

Colorado's ten state priorities are:

1) Improve healthy birth outcomes for pregnant women
2) Improve access to health care for MCH populations
3) Improve immunization rates for all children
4) Reduce the adolescent fertility rate
5) Reduce rates of child and adolescent motor vehicle injury and death
6) Improve preconceptual health among women
7) Reduce the incidence of overweight among children and teens
8) Improve the mental health of MCH populations
9) Improve the health of children
10) Reduce the use of tobacco, alcohol and other drugs among MCH populations.

A chart showing the state priorities, the national performance measures, and the state performance measures is attached to this section. "Priority Areas, National Performance Measures, and State Performance Measures Colorado FY 06" delineates the relationship between the priority areas and the two types of performance measures.

The process used to determine the state's priority needs involved assessing the needs, examining the capacity, selecting the priority needs and performance measures, and setting the targets. We began with a comprehensive analysis of current data on the health status of the maternal and child populations that was utilized by state and local stakeholders and state-level program administrators and consultants in determining what the priority needs would be. This analysis, "The Health Status of Colorado's Maternal and Child Health Population" is contained in the Section II narrative.

In the 2005 Needs Assessment process, the input of multiple stakeholders was solicited. This was expedited through the use of internet resources that have become available in recent years. We began the needs assessment process with an electronic survey designed to solicit the perception of stakeholders from around the state regarding the needs and emerging issues. Our intent was to identify any additional issues for which we needed to gather data and information.

The health status report was successful in providing needed information from the responses of over 700 individuals, identifying access to care and the lack of insurance for specific populations

and types of care as issues of concern for which we needed to seek out additional data. Such data was included in the "The Health Status of Colorado's Maternal and Child Health Populations" as a result. We also used an Internet-based technology, WebIQ, for the more comprehensive Stakeholder Input process that responded to the data in the health status report. In the 2005 Needs Assessment process a series of meetings that used Internet technology connected the stakeholders in a discussion of priorities and resulted in a ranking of the priorities.

The use of the Internet-based survey tool and the WebIQ technology for the participation of MCH stakeholders facilitated the participation of a much broader spectrum of stakeholders than was possible five years ago. The amount of time that the participants needed to commit to was limited to one hour sessions with several options of available dates and times. Participants could "attend" from their own offices, and could gathering appropriate staff members together who could participate simultaneously by conference call and through their computer keyboards. The technology allowed the participants' input to be displayed immediately, commented on, added to, voted on, and ranked using standardized criteria.

The data contained in "The Health Status of Colorado's Maternal and Child Health Population" provided the evidence upon which Colorado's priorities are based. The list of priorities for the next five years is similar to the list that was in effect for the past five years. This finding underscores the importance of addressing basic maternal and child health issues which may not be easily accomplished. Access to care, reduction of harmful behaviors, and improvement in healthy behaviors over time will lead us closer to fulfilling the goals that our priorities promise. Colorado's priorities cover a broad range of issues that are all important to the health of mothers and children in our state.

FY 2006 New Performance Measures

The following summarizes plans for addressing the new FY 2006 state performance measures resulting from the needs assessment process.

New State Performance Measure 4

The rate of birth (per 1,000) for Latinas aged 15-17

The FY 2006 target is set at 73.7 births per 1,000 teens age 15-17.

This target is the baseline level of Latina teen fertility for calendar 2003, the most current available. The primary intent of this project is to gain a fundamental understanding of the Latino/a teens, parents, and community providers' viewpoint on teen sexuality and pregnancy prevention. The Latina Teen Fertility Project has two phases (I and II) and the final report will provide baseline information for this measure.

The first phase of the Latina Teen Fertility Project began in August 2004 and continued through FY 2005. A contractor was hired to develop an exploratory study to explore the various sociocultural factors related to Hispanic/Latina teen pregnancy in Colorado. The contractor organized and facilitated 5 focus groups with community members in metro Denver to obtain the feedback of U.S.-born Latino/a teens and parents. Also, two meetings were held with representatives from community-based organizations that work directly with Latino/a adolescents to ask for their feedback regarding these complex issues. The same process was repeated to obtain the feedback of foreign-born Latinas/os, Spanish-speaking community members.

The findings from this first phase provided a wealth of information for consideration when developing initiatives to address Hispanic/Latina teen pregnancy. Input from teens, parents, and community leaders demonstrated a critical need for more leadership from public health agencies in this area including providing funding and technical assistance for programs, and a firm and

genuine commitment to work in collaboration with the community to address Hispanic/Latina teen pregnancy. The report from the first phase is attached to this section, after the injury fact sheet.

After the completion of Phase II begun in FY 2005, the results from both phases will be analyzed and compared, yielding possible appropriate programs strategies recognizing socio-cultural differences. The state health department will present the final findings of the Latina Teen Fertility Project to the public, and sponsor a community dialogue to discuss next steps. The project may be expanded (contingent upon funding) by conducting focus groups throughout Colorado to obtain representational statewide data.

Targets and specific plans for follow-up on this measure will be set during FY 2006.

New State Performance Measure 5

The motor vehicle death rate among teens 15-19

The FY 2006 target is 28.0 deaths per 100,000 teens.

According to the Health Statistics Section at the state health department, the motor vehicle death rate among teens age 15-19 in 2003 was 29.0 per 100,000. A fact sheet on deaths and hospitalizations involving teen drivers is attached to this section, following the chart on priorities.

Utilizing the Adolescent Health in Colorado 2003 Report, and building on existing statewide efforts, the Advisory Council on Adolescent Health will meet in the fall of 2005 to develop a work plan to decrease motor vehicle deaths among teens in Colorado. Experts on teen motor vehicle safety will present data to the Council, and state and local and best practices will be identified. We will invite participation from a broad base of stakeholders including the Injury Prevention Section at the state health department; AAA Colorado; representatives from law enforcement, schools, and injury prevention coalitions; parents; and teens. The steps will be incorporated into model work plans for local health departments and used to guide the activities of the state health department's Adolescent Health Program.

New State Performance Measure 6

The percent of mothers smoking during the three months before pregnancy

The FY 2006 target is 15.9 percent.

In Colorado, one out of every eight low birth weight births can be attributed to the fact that the mother was a smoker. In 2003, according to PRAMS data, 18.7 percent of women in Colorado were smokers prior to conception.

The state tobacco program (STEPP) and the Women's Health Section will continue to jointly conduct smoking cessation trainings for prenatal providers. Trainings are offered to prenatal providers from private practice, WIC, Prenatal Plus, Nurse Home Visitor Programs, local health departments, and hospitals on how to implement the 5A's counseling intervention with their patients and incorporate the technique into routine care. Another cessation initiative underway involves physician education through hospital grand rounds. Physicians deliver presentations to audiences of other physicians on tobacco cessation interventions and resources. The Women's Health Section is supporting these efforts by participating in displays and distribution of materials. Assessment and direct counseling for clients will continue at 30 family planning delegate agencies serving 55,000 clients per year and 27 Prenatal Plus agencies serving 3,500 clients per year.

Colorado was selected to participate in the Action Learning Lab: Tobacco Prevention and Cessation for Women of Reproductive Age sponsored by the American College of Obstetricians and Gynecologists (ACOG) and the Association of Maternal and Child Health Programs (AMCHP). The Colorado state team includes members from STEPP, the Women's Health Section, ACOG, Planned Parenthood of the Rocky Mountains, and the March of Dimes. A statewide action plan is being developed to increase collaboration and comprehensive implementation. Through trainings and presentations, we will educate health care providers and provide smoking cessation materials at no charge.

STEPP will promote awareness of the Colorado Quitline (smoking cessation telephone line) among pregnant smokers with television ads that will run statewide using the "You Have the Power" ad from the CDC's media resource center. In addition, several different print ads targeting pregnant smokers will be provided to local health departments for their use in community newspapers.

New State Performance Measure 7

The proportion of all children 2-14 whose BMI is greater than 85 percent weight for height

The target has not yet been set.

Data from the 2004 Colorado Child Health Survey will be analyzed for this measure. Survey questions focus on the health and health behaviors of a randomly selected child in the household (the full format of the survey and all survey questions are attached to Section III F). Parents are asked to actually weigh and measure the child prior to the survey and there are an additional nine questions regarding nutrition.

Data from the 2004 Colorado Child Health Survey indicated that 14.2 percent of children have a BMI greater than 85 percent weight for height. The full survey will be analyzed along with demographic and companion information and a target will be determined.

The state health department's Child, Adolescent and School Health Section, Colorado Physical Activity and Nutrition (COPAN) Program, and WIC Program will work collaboratively with the Healthy Child Care Colorado Project, the Coordinated School Health Program, the Colorado Department of Education and other interested state and local agencies and organizations to develop strategic state and local action steps to address the issue of overweight/obesity among children and adolescents.

In addition, the Child, Adolescent and School Health Section will assess the impact of providing "incentive grants" to local public health agencies in communities whose schools are receiving CDC Coordinated School Health grants. The efficacy and impact of this funding in addressing obesity prevention and healthy lifestyle promotion among the school age population will also be determined.

New State Performance Measure 8

The percent of children who have difficulty with emotions, concentration or behavior

The target for FY 2006 is 28.0 percent.

The target is based on the preliminary estimate of children with difficulties with emotions, concentration or behavior using preliminary 2004 data from the Child Health Survey.

The Child, Adolescent and School Health Section within the Maternal and Child Health Program

at the Colorado Department of Public Health and Environment has applied for a grant from MCHB to improve coordination of state mental health prevention, intervention and treatment systems through a collaborative planning process. Recommendations will be prioritized and operationalized through the Prevention Leadership Council, an existing state-level body that is charged with coordinating and streamlining state and federally funded programs that is led by the Colorado Department of Public Health and Environment. Improved state coordination will lead to local services integration, increased access to mental health care, and better mental health outcomes among children, youth and families. If the MCHB grant is not funded, alternate funding will be sought.

New State Performance Measure 9

The percent of center-based child care programs using a child care nurse consultant

The target has not yet been set.

Qualistar Early Learning is a nonprofit organization dedicated to improving child development and age-appropriate learning experiences for all children. It conducts an annual survey of child care providers through the child care resource and referral network throughout the state. In order to obtain baseline data for this performance measure, the MCH Program plans to sponsor questions on the Qualistar survey to determine how many child care providers are actively using child care health consultants and to ascertain how satisfied the provider is with the consultation services they are receiving.

New State Performance Measure 10

The proportion of high school students reporting binge drinking in the past month

The FY 2006 target is 29.0 percent.

According to the 2003 Colorado Youth Risk Behavior Survey, 29.1 percent of students reported report having drunk five or more drinks in a row (binge drinking).

Colorado has received a $2,350,965 grant from the Substance Abuse and Mental Health Services Administration to advance community-based programs for substance abuse prevention, mental health promotion and mental illness prevention. The program, which is housed in the Alcohol and Drug Abuse Division (ADAD) at the Colorado Department of Human Services, is a collaborative effort between the ADAD and the Prevention Leadership Council. The Director of the Adolescent Health Program will work collaboratively with ADAD, the Advisory Committee and the Underage Drinking Workgroup to develop strategic state and local action steps to address the issue of binge drinking among teen.

/2007/

No changes were made. //2007//

/2008/
State Performance Measure 4, the rate of birth (per 1,000) for Latinas aged 15-17, has been discontinued as the activities designated for state staff are now complete. Future activities regarding this project will be done by a non-profit organization. The state will continue to monitor activities but will no longer take the lead. See State Performance Measure 4 narrative for more information.

State staff are engaging in a critical review of state-level MCH activities during the summer and fall to better re-define priorities and state-level work in response to data trends and MCH funding

reductions. //2008//

/2009/ State Performance Measure 6 Smoking Prior to Pregnancy will be discontinued. The activities associated with this measure are virtually the same as those associated with National Performance Measure 15. Work will continue in this area, but it will be reported for National Performance Measure 15. //2009//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	98	98	98	100	100
Annual Indicator	97.5	98.0	100.0	100.0	100.0
Numerator	66834	67920	213	77	54
Denominator	68537	69304	213	77	54
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

Notes - 2007
Data shown for reporting year 2007 are based on calendar 2006 births.

Notes - 2006
Data shown for reporting year 2006 are based on calendar 2005 births.

Notes - 2005
Data shown for reporting year 2005 are based on calendar 2004 births.

For 2005, and henceforth, the denominator is the number of newborns with positive newborn screening results and the numerator is the number of those newborns with positive screens who received timely follow-up to the point of diagnosis and initiation of treatment. Prior to 2005, the denominator is the number of births and the numerator is the number of babies who were screened.

a. Last Year's Accomplishments
The 2006 target was 100 percent and it was met.

The federal government and the March of Dimes are strongly encouraging all states to adopt expanded newborn screening (NBS) that allows screening for up to 28 conditions. This will result in all infants being screened for similar conditions across all states. Colorado screened for seven diseases until July 2006, when expanded NBS was adopted. All of the conditions that were added to Colorado's screen are in the category of "inborn errors of metabolism" (IEMs). IEMs are problems present at birth that impact a baby's ability to metabolize certain substances found in

food. These errors in metabolism, if not found and treated early, can cause acute illness leading to permanent physical and mental disability and in some cases death. The IEMs fall into three categories: (inability to metabolize) organic acids, amino acids, and fatty acids. Taken together, these IEMs occur in the population at the rate of 1:4,000 -- a high incidence rate. In calendar year 2007 over 200 abnormal screens for IEMs were followed and 20 Colorado children were diagnosed with IEMs.

With the implementation of expanded newborn screening, it was imperative that the Colorado newborn screening lab receive the newborn screening specimen as soon as possible, ideally within three days of birth. Newborns with certain inherited errors of metabolism can become sick and die within the first week of life. The symptoms of these conditions are so non-specific that a baby in a NICU can be receiving treatment that is actually worsening its condition.

To shorten the length of time between birth and receipt of the newborn screening specimen, as well as to improve other parameters, the Newborn Screening Laboratory instituted a quarterly "report card" that is sent to the birthing hospitals in the state. It gives each hospital a numerical score on how well the hospital performs with regard to practices that can improve or reduce the efficacy of newborn screening. The scores are determined by where that hospital's performance falls along the spectrum of best to worst performing hospitals. The hospital receives its own and for comparison the highest and lowest average state scores for comparison. Feedback has been gratifying, as a number of hospitals have contacted the lab for advice on how they can improve their performance.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Colorado Newborn screening Lab developed a report card for hopitals related to areas for improvement regarding efficacy of screening efforts.				X
2. The Lab provided technical assistance to hopitals to make improvements.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Colorado Newborn Screening Laboratory contracted with the Wisconsin State Laboratory to test Colorado's newborn screening specimens in the event that the Colorado laboratory cannot function. Many state newborn screening programs are creating these arrangements after the experience of Hurricane Katrina. The follow-up program (which, in Colorado, is not located in the Laboratory Division) is in the process of defining how it will function in such an eventuality.

Work continued on adding DNA mutation analysis to Colorado's Cystic Fibrosis (CF) screening program. A decision has been made on how to report results that will follow a different pattern from traditional reporting of newborn screening results. The addition of DNA mutation analysis will be added to the CF screening program by the end of the year.

In November 2007, the Colorado Board of Health approved eliminating routine screening for certain conditions on Colorado's mandated second screen. Disease specialists consulted with

the laboratory to give careful consideration to determining which conditions could be safely removed from the routine second screen.

c. Plan for the Coming Year

The Newborn Screening Program Advisory Committee's membership will be reviewed to remove inactive members and replace them with new people from their sponsoring agencies. Membership categories will be reviewed to determine if any need to be added or eliminated. Changes in membership categories will require updates to the committee's by-laws. These moves are made to ensure active participation by all of the entities and agencies deemed to be vital to advising the state health department on issues related to newborn screening.

Colorado's Newborn Screening Follow-up Program will create a disaster plan addressing how to handle the follow-up of abnormal newborn screening tests. The lab's disaster plan transfers the responsibility of reporting abnormal screens to the Newborn Screening Follow-up Program. The disaster plan proposal will reviewed by the state lab, the Newborn Screening Program Advisory Committee, state health department staff responsible for disaster planning, as well as senior management before being finalized.

Through shared software, Colorado is considering integrating the results from newborn screening and the immunization registry. This would allow health care providers access to both sets of results simultaneously via a secure access system.

The follow-up coordinators for newborn metabolic screening and newborn hearing screening will cross-train to allow coverage for programs when staff is out of the office.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	55	55	57.4	57.4	57.4
Annual Indicator	57.4	57.4	57.4	57.4	59.1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	60	60	60	65	65

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The 2007 target was 57.4 percent. The target was exceeded with 59.1 percent achieved.

This performance measure has two areas of focus areas, family satisfaction and partnering in decision-making. The strategies to meet these outcomes were implemented as two separate initiatives.

A family-satisfaction survey was completed to assess quality of care coordination services. The survey results indicated that 93 percent of families with long-standing partnership with their local Title V agency, reported satisfaction with their care coordination services. Local program offices reported that satisfaction rates are often influenced by systems barriers, such as lack of Medicaid providers, inadequate health insurance benefits, and inequitable services in rural areas.

This measure is driven by families' ability to make informed decisions regarding the health and well being of their child. Strong partnerships between the family and the service provider increase family satisfaction rates. A statewide scan was completed to identify and assess current leadership trainings offered to families. Results of the scan determined that trainings offered to families focused primarily on parenting and overall involvement in their child's life. Families who have children with special health care needs requested trainings beyond parenting skills. These families asked for information about human service systems, health insurance, advocacy and overall leadership. As a result of the survey, leadership development for families was selected as a primary focus of family satisfaction.

Family leadership assures that families are equipped to actively partner with their service provider. Colorado's Family Engagement Task Force was renamed the Family Leadership Task Force, to more accurately reflect the revised focus. This Task Force involved family, community and state-based consultants in the Children with Special Health Care Needs (CSHCN) Unit's strategic planning process. The involvement of families led to a heightened awareness of the benefits of family involvement at a local and state level.

The CSHCN Unit supported a team to attend a national training on the Connecticut Parent Leadership Training Institute (PLTI) Curriculum www.cga.org/plti to determine its applicability to Colorado. The community-based team reviewed the PLTI curriculum and determined that it would meet CSHCN's program needs. An on-going collaboration with the Connecticut coalition was established with the intent of bringing the curriculum to Colorado.

The Title V Regional Family Coordinators met for a statewide meeting. The meeting included Family-to-Family Health Information Center Project updates and local coalition building skills building sessions. Electronic health records care coordination and family support activities were also discussed.

Title V partnered with the University of Colorado Health Sciences Center/JFK partners, (Colorado's designated AUCD), to offer a statewide conference on Cultural Competence. Attendees included representatives from families, EPSDT outreach, Title V Regional offices, family-advocacy, Colorado State University, and Part C. As a result of positive feedback, a series of trainings will be developed and offered in upcoming years.

Family leaders were integrated into Colorado Medical Home Initiative activities and trainings. As

a result, family leaders across the state became more familiar with the medical home concept and their role in assuring quality health care systems for children in Colorado.

A statewide Family Leadership Coalition was developed by the CSHCN Unit. Members included emerging family leaders and agency partners such as Family Voices Colorado, Head Start, the Federation of Families for Children's Mental Health of Colorado and PEAK Parent Center. Other partners included state agencies such as the Lieutenant Governor's Office; Colorado Department of Human Services, Division of Developmental Disabilities; and the University of Colorado Health Sciences Systems, Association of University Centers on Disabilities (AUCD).

A statewide Family Leadership Forum was held to discuss strategies for establishing and sustaining a strong family leaders network. Blending strong civic engagement with leadership skills, the Forum was designed to gather input from stakeholders on how family leaders can assist in policy and systems change activities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conducted a Family Satisfaction Survey.				X
2. Conducted a scan of current family leadership trainings available throughout the state.				X
3. Continued involvement with Colorado's Early Childhood State Systems Team.				X
4. Sponsored families to attend relevant local, state and national conferences.	X			X
5. Changed focus from family involvement to family leadership.				X
6. Developed a parent/professional partnerships within the Colorado Medical Home Initiative.				X
7.				
8.				
9.				
10.				

b. Current Activities

Health care reform remained a state priority with work accomplished through the Colorado's SB07-208 Commission on Health Care Reform. Several family-leaders were involved in the work of this Commission to ensure that family satisfaction and informed decision-making were a part of this critical process.

As part of the Colorado Medical Home Initiative (CMHI), family leadership principles were integrated into the development of the Medical Home model in Colorado. One of the four goals of Colorado's Medical Home Initiative is "Families will understand the concepts/components of a Medical Home approach and will advocate for them." Family Leaders were involved in the development and implementation of the CMHI strategic plan. The CSHCN Unit funded representatives from three El Grupo Vida, Family Voices and Colorado Hands and Voices (family-advocacy organizations) to participate in activities ensuring diverse perspectives and statewide representation.

In collaboration with Family Voices Colorado, the CSHCN Unit supported the development and implementation of Colorado's Family Leadership Registry to be completed next year.

A Summit on Cultural Competence was planned in collaboration with the National Center on Cultural Competence and held in October 2008.

c. Plan for the Coming Year
The Family Leadership Training Institute (FLTI) will be launched in the fall. For three years, Connecticut staff will mentor and support Colorado's efforts to assure the quality and integrity of the adapted curriculum. Classes will occur in communities composed of participants who have demonstrated a commitment to family involvement specifically in the area of systems change.

Colorado's Summit on Cultural Competence will be held in October and will feature Wendy Jones of the National Center on Cultural Competence. A follow-up session is planned for April that will provide continued technical assistance to communities and agencies.

The Colorado Medical Home Initiative (CMHI) will be implemented and will include a strong emphasis on parent/professional partnerships within the medical home model. The CMHI is committed to the concept of family-centered and culturally competent care as part of the medical home model. Youth leadership development will also be included.

The Colorado Family Leadership Registry will be functional and available for stakeholders and families. Families, agencies, communities and policy-makers will be able to use this tool to more meaningfully integrate family participation.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	50	50	51.7	51.7	51.7
Annual Indicator	51.7	51.7	51.7	51.7	48.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	51.7	51.7	51.7	51.7	51.7

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The 2007 target was 48.2 percent. The target was exceeded with 51.7 percent achieved.

The Medical Home Initiative housed within the Colorado Department of Public Health and Environment (CDPHE), Children with Special Health Care Needs Unit (CSHCN), has evolved and expanded from a medical home approach with a focus on individual primary care practices through the Medical Home Learning Collaborative to a public health medical home systems approach. The Medical Home Advisory Board (MHAB) continued quarterly meetings attended by over 40 community partners and developed the Medical Home Strategic Plan. The MHAB established four Task Forces based on the MHAB Goals:

Provider Practice Management Task Force: All providers will understand the components of the medical home approach and will implement them.

Family Leadership Task Force: Families understand the concepts/components of the medical home approach and advocate for them.

Evaluation Task Force: Outcomes are evaluated and systems are monitored to assure quality.

Messaging Task Force: Research and outcomes are communicated clearly to providers, families, and the community.

The CSHCN Unit established the Medical Home Initiative as a primary program within the unit and identified a Medical Home Director and Health Services Director. The Medical Home Initiative goals are: to assure that all providers of a child's health care operate as a team; that families are critical members of that team; and that all team members understand the importance of quality, coordinated medical, mental, and oral health care.

In May, the Colorado General Assembly and the Governor approved legislation increasing the number of children who receive care consistent with the medical home approach. Senate Bill-130 defined a medical home as encompassing medical, mental, and oral health care. The bill also described the importance of a team approach in coordinating health care services and promoting partnerships between families and providers. The Department of Health Care Policy and Financing (HCPF) was designated as the lead agency in assuring an increase in the number of medical homes available for Medicaid and CHP+ eligible children. CDPHE through the Medical Home Initiative and the Medical Home Advisory Board is responsible for collaborating with HCPF to implement requirements of this bill. The HCPF and CDPHE were directed to develop medical home standards as a requirement of this legislation. The MHAB Evaluation Taskforce was assigned the lead in the development of the Medical Home Standards. (Attachment)

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Medical Home Initiative expanded from a medical home approach with a focus on individual primary care practices to a public health medical home systems approach.				X
2. The Medical Home Advisory Board (MHAB) continued quarterly meetings.				X
3. The MHAB established four Taskforces based on the MHAB Goals.				X
4. CDPHE through the Medical Home Initiative and the Medical Home Advisory Board is responsible for collaborating with				X

another department to implement requirements of the medical home legislations.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Medical Home Advisory Board (MHAB) developed an organizational structure with defined meeting agendas, membership, taskforce roles, and responsibilities. The Evaluation Taskforce developed Medical Home Standards (MH Standards) for each of the medical home components that assure a quality pediatric health care system. The MH Standards address care that is: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally responsive.

MHAB members, family leaders, community partners, organizations, and providers completed a Medical Home Standards Survey in January 2008 to prioritize and evaluate the initial MH Standards proposed by the MHAB Evaluation Task Force. The Evaluation Task Force used the survey results to finalize the Standards. The Standards and the defined Principles and Assurances were presented to the MHAB Steering Committee and the Medical Home Advisory Board in May. The Standards were submitted to CDPHE and HCPF for review and to determine which Standards would be used by HCPF to designate a primary care practice or provider as a medical home.

The department was selected to receive a HRSA State Implementation Grant for Integrated Community Systems for CSHCN. This funding will help the Medical Home Initiative staff in building working relationships between public health and health care providers at the state and community levels.

c. Plan for the Coming Year
The MHAB and the Taskforces are responsible for developing an implementation plan over the next year based on acquired feedback.

The Family Leadership Taskforce will share feedback with other MHAB Taskforces that was gathered from families through Family Leadership Institute, HCP Family Coordinators, and Family Leadership TaskForce collaboration. This information will be used to shape products and processes.

The MHAB Messaging Taskforce will develop materials and resources for families, providers, and the community and will complete the website.

The MHAB Provider Practice Management Taskforce will use the Standards to determine what support services, technical assistance, and training providers would need for implementation. This information will be used to guide the development of provider and community medical home systems training programs including the development of a web site, training tool kits, and other materials.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	55	55	58.2	58.2	58.2
Annual Indicator	58.2	58.2	58.2	58.2	59.1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	60	60	60	60	60

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The 2007 target was 58.2 percent. The target was exceeded with 59.1 percent achieved.

Covering Kids and Families and Medicaid & Kids, two statewide collaborative organizations focused on increasing access to insurance for children, continued to share vital information about ongoing changes associated with the Medicaid and Child Health Plan Plus (CHP+) programs. Changes associated with the federal Deficit Reduction Act (DRA) were a primary focus.

As part of the CSHCN State Strategic Plan, results were published from an environmental scan of school health service delivery in Colorado public schools. Focus groups held around the state were used to gather information about the strengths and barriers associated with accessing mental health services in various communities.

The passage of Medical Home legislation, SB 07-130, outlined activities that need to be accomplished between the CSHCN Unit and the Department of Health Care Policy & Financing that houses the Medicaid and CHP+ programs. The legislature identified the need for specific criteria for determining which providers can be identified as a Medical Home.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participated in statewide coalitions focused on access to care.				X
2. Carried out focus groups to identify the needs related to childhood mental heath and associated barriers.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Medicaid & Kids and the Covering Kids and Families Coalitions continued to work with statewide partners to share information and to simplify the public insurance application process.

The DRA rules went into effect resulting in barriers to enrollments in public insurance programs.

Presumptive eligibility for pregnant women and children has been reinstituted.

Community-based sites are being trained to enroll participants directly into CBMS, the state electronic application program for both Medicaid and CHP+.

The Blue Ribbon Policy Council is finalizing the State Strategic Plan for Early Childhood Mental Health. It includes a recommendation for an Early Childhood Commission to evaluate accessing health and mental health services for young children and their families.

The SB 07-130 Medical Home Initiative has let to an increase in collaboration around and better understanding of EPSDT and the requirements of children with special health care needs.

The System of Care Collaborative of Colorado, a mental health systems development initiative, offered two technical assistance conferences one in Denver and the other in western Colorado. The meetings highlighted how access to care can be improved by the partnering of a family member and a health professional.

The Family and Child Subcommittee of the Mental Health Advisory Council continued to address how to improve access to mental health services by focusing on how to best serve children and families.

c. Plan for the Coming Year
Information sharing will continue through the Medicaid & Kids and the Covering Kids & Families Coalitions.

The Medical Home Initiative will continue to work collaboratively with EPSDT to improve provider access and support the need for timely and culturally responsive family-centered care. Work will continue with local pediatricians to expand the numbers of providers willing to accept public insurance reimbursement.

The System of Care Collaborative of Colorado, LINKS and the Family and Child subcommittee of the Mental Health Advisory Council will work together to identify how best to enhance access to care, while maintaining a family-centered mental health focus.

The Blue Ribbon Policy Council will summarize information from the CSHCN Strategic Plan addressing how to access care from the perspective of prevention, promotion and intervention strategies.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	75	75	77.4	77.4	77.4
Annual Indicator	77.4	77.4	77.4	77.4	87.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	87.8	87.8	88	89	89

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The 2007 target was 77.4 percent. The target was exceeded with 87.4 acheived.

The Local Systems Section of the Children with Special Health Care Needs Unit (CSHCN) that includes the Health Care Program for Children with Special Needs (HCP) and its sub-programs are responsible for achieving this measure. All Children Special Health Care Needs (CSHCN) Unit programs work toward building a comprehensive, coordinated Medical Home System that is accessible, family centered, coordinated, compassionate, comprehensive, culturally respectful and community-based. CSHCN efforts are guided by the recently developed Medical Home Framework system.

The Unit's sections and programs have better defined their unique role within the pediatric service system. It includes health care consultation, health care coordination, access and assuring family

involvement in health care.

The Unit provided a variety of services to assure the building of local medical home systems with services better organized for families. Community trainings were held to establish a working relationship with Part C/Early Childhood Connections (Part C/ECC). New marketing materials for the HCP and ECC relationship were used.

Specialty clinic services, including developmental and genetics, provided access to specialty care in rural communities to approximately 1,300 children. Clinic staff also assisted in coordinating specialty and primary care for families, consistent with the Unit's medical home approach.

The Care Coordination Project, that includes the Traumatic Brain Injury Care Coordination Program, continued to identify barriers to care, such as the those associated with mental health services.

There are now six respite programs developed through community and state coalition building activities.

The Inclusive Communities in Faith Task Force (ICFTF) continued to connect families' faith communities to other resources supports. Although, the ICFTF is located in the Denver area, it is a promising model for other communities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Unit's sections and programs have better defined their unique role.				X
2. Community trainings were held to establish a working relationship with Part C/Early Childhood Connections			X	
3. Provided access to specialty care in rural communities to approximately 1,300 children.	X	X		
4. Continued to support the six respite programs.	X	X		
5. Support and participate in the Inclusive Communities in Faith Taskforce.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Unit developed a Medical Home Action Guide that provides strategies for implementing this approach. The action guide incorporates the three services components (care coordination, clinics, and interagency collaboration). It is at http://www.cdphe.state.co.us/ps/mch/actionguides.html. Training on how to use the guide was offered during the spring meeting.

MCH plans were developed in all 17 county health department based programs.

The CSHCN Unit worked with the Medicaid and CHP+ staff to coordinate EPSDT outreach efforts for families and providers.

Provided consultation to Part C/ECC staff to promote a medical home approach for children

enrolled in that system.

An evaluation report for HCP care coordination should be completed in the summer. The report reviewed the history of HCP care coordination and included available evaluation data from 2000-2006.

Care coordination was better defined is defined in terms of outreach, level I, II and III and care coordination at http://www.cdphe.state.co.us/ps/hcp/form/index.html.

Local coalitions were formed to solicit community support and assistance in newborn screening follow-up. The coalitions are working to improve follow-up rates and improve services.

The CSHCN Unit worked with the Public Health Alliance in Colorado to explore how the implementation of a medical home effort fits with the goals of local public health agencies.

The CSHCN Unit received a HRSA MCHB grant to help fund the implementation of a medical home system.

c. Plan for the Coming Year
HCP local plans, focused on community-based implementation of the medical home model will begin implementation in October.

The CSHCN Unit will continue to develop the state-level infrastructure of the Colorado Medical Home Initiative. These efforts will be supported through grants and the voluntary efforts of the initiative's members. Products to be developed include: a Medical Home website; a surveys on provider's practice standards; and family outreach and training.

Local HCP offices will be trained on the new levels of care coordination and accompanying standards.

The Unit will continue to work with Part C/ECC and EPSDT to define roles so that local systems of care can be organized for families without duplication.

Using funds from a HRSA grant, the Newborn Hearing Program will continue to build local coalitions for follow-up on missing screenings. Also as part of this grant, the program will participate in a national Medical Home Learning Collaborative with the National Initiatives for Children's Health Quality.

The CSHCN Unit will continue to partner with the Public Health Alliance and participate in the Rocky Mountain Public Health Education Consortium to develop training on the ten essential public health services adapted to address building a medical home system.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	3.3	8	10	12	14
Annual Indicator	5.8	5.8	5.8	5.8	47
Numerator					
Denominator					

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	47	47	48	48	49

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The 2007 target was 14 percent. The target was exceeded with 47 percent achieved.

The National Governor's Association (NGA) Policy Academy, Transition Team for Colorado, which included key CSHCN Program staff, continued collaborative efforts following the conclusion of the Academy's official cycle. A transition objective was included as part of the State Plan for Prevention and Treatment for Children and Youth developed by the inter-departmental Colorado Prevention Leadership Council. Specific benchmarks focused on charting existing state services; developing ways to share transition resources among partner agencies; promoting greater youth involvement and family leadership; and providing cross training and professional development activities along with printed and web-based transition resource materials. The NGA Transition Team also launched a web-based directory of transition resources entitled YouthNet.

State staff continued work with regional staff to provide health care transition information and resource materials at local school district Transition Fairs. These school district connections proved very helpful in promoting health care as an essential component of transition and in promoting a Medical Home Approach for comprehensive and collaborative, family-centered health care services.

The Guide to Transition Services for Youth with Special Health Care Needs, a joint project with the Colorado Department of Education, was completed and distributed to all regional HCP offices.

Fast Facts sheets (attachments) were expanded and updated to provide local offices and community partners with a quick overview of issues surrounding health care transition, as well as state and national resource information.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. A transition objective was included in the the State Plan for Prevention and Treatment for Children and Youth.				X
2. The NGA Transition Team launched a web-based directory of transition resources entitled YouthNet.			X	
3. Provided health care transition information and resource materials at local school district Transition Fairs.		X	X	
4. The Guide to Transition Services for Youth with Special Health Care Needs, a joint project with the Colorado Department of Education, was completed and distributed to all regional HCP offices.			X	
5. Fast Facts sheets were expanded and updated to provide local offices and community partners.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Colorado Department of Education and the Colorado Department of Public Health and Environment's, Child and Adolescent School Health Program expanded the Guide to Transition Services for Youth with Special Health Care Needs and distribute it statewide through the public schools as part of the existing Transition Tool Kit, Chart a Course for the Future.

The Colorado Medical Home Initiative continued to define the indicators associated with a Medical Home Approach. A transition priority was to prepare resource materials and offer technical assistance to help local offices incorporate health care transition planning as an essential element in building a Medical Home approach. The strategies focused on leveraging the strengths and assets of partners, utilizing family leaders and connecting with local primary care and specialty care providers.

Information relevant to health care and transition was incorporated into the Colorado Developmental Disabilities Council's 2007-2011 Five-Year Plan.

Policies and standards for Care Coordination and HCP Specialty Clinic practices were revised to include guidelines for health care transition.

CSHCN and Child and Adolescent Health Program staff worked to involve youth in decisions about transition issues for youth with special needs through the Youth Partnership

c. Plan for the Coming Year

Health care transition will continue to be promoted within the context of a Medical Home approach. Technical assistance to incorporate health care transition as an essential element of a Medical Home approach will be a priority as local offices begin crafting a new three-year work plan which emphasizes specific objectives.

Supplemental materials and training will be developed to complement the strategies outlined in the Medical Home Action Guide.

Implementation of Projects outlined in the State Plan for Prevention and Treatment for Children and Youth from the Colorado Prevention Leadership Council will continue.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	86	88	90	90	90
Annual Indicator	64.3	67.5	77.1	83.4	80
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	85	90	90	90	90

Notes - 2007
Data shown for 2007 are data for the 4:3:1:3:3 series for calendar year 2006 from the National Immunization Survey. See http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis

Notes - 2006
Data shown for 2006 are 2005 data for the 4:3:1:3:3 series from the National Immunization Survey.

Notes - 2005
Data shown for 2005 are 2004 data for the 4:3:1:3:3 series from the National Immunization Survey.

a. Last Year's Accomplishments
The 2007 target was 90 percent. The target was not met but progress has been made.

GIS mapping of surrogate measures for low rates of immunization and local immunization registry data assisted local health providers in targeting immunization activities. Denver Health and Hospitals used the results of the mapping of local immunization registry data to place additional immunization clinics.

The Colorado Vaccines for Children (VFC) Program developed a two-part training for medical assistants responsible for administering the VFC program in private provider offices. Three trainings were held throughout the state and 51 medical assistants participated.

The Colorado Department of Health and Public Environment, Immunization Program continued to identify pockets of need. Auditing a random sample of school records provided more accurate data regarding kindergarten immunization levels for the state. Assisting local health providers in over sampling led to the estimation of county specific kindergarten immunization levels.

Three hundred and twenty-seven VFC Program/Assessment, Feedback, Incentives, exchange site visits were conducted in public and private provider offices.

The Immunization Program worked with the Colorado Children's Immunization Coalition to host National Infant Immunization Week activities focused on early childhood vaccinations. Coalition members included The Children's Hospital, local public health agencies, local immunization coalitions, private providers, community health centers, community organizations, medical

associations, and national CDC staff.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ensured VFC/AFIX visits are conducted in private provider offices and community health centers.	X	X	X	X
2. Continued collaboration through VACC.				X
3. Engaged in immunization week national infant Immunization Week activities.	X	X	X	X
4. Used GIS information to better target immunization activities.			X	X
5. Trained medical assistance responsible for Vaccines for Kids programs in private practice offices.	X	X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Vaccine Advisory Committee for Colorado (VACC) was convened in November with Lieutenant Governor Barbara O'Brien as a co-chairperson. The committee's mission is to ensure that every Colorado parent who wants his or her child fully immunized will experience no financial or structural barriers. The goals of VACC were outlined and the group developed a workplan to direct their activities.

The VACC Steering Committee established five subcommittees: Immunization Best Practices, CIIS Registry, Innovative Health Programs, Special Projects and Public Awareness and Education. The subcommittees will be responsible for carrying out workplan goals and objectives. The VACC Steering Committee will also expand its advisory role to the Department of Public Health and Environment and the Lieutenant Governor's Office.

c. Plan for the Coming Year

The coalition will carry out the objectives and benchmarks associated with the 2008 workplan.

The Steering Committee will complete an inventory of public and private financing sources available for increasing childhood immunization rates and offer recommendations for maximizing these funding streams through integration and partnership strategies. It will also see that immunization information is collected at the household level, either through the Child Health Survey, PRAMS, BRFSS or the newly created Colorado Household Survey.

The Innovative Health Programs and Public Awareness and Education Subcommittees will work with other groups to ensure that any approved Colorado health reform initiatives includes activities to increase the state's rates of childhood immunizations.

The Innovative Health Programs Subcommittee will initiate a study of Medicaid and Child Health Plan Plus and issue recommendations to improve immunization rates among children covered.

The CIIS Registry Subcommittee will develop a white paper on best practices for building a statewide immunization strategy that uses current health information technology and develops between various providers statewide information systems.

The Best Practices Subcommittee will assess the socio-economic determinants of under-immunization and recommend strategies for targeting at-risk children. The committee will also complete an inventory of current state and local immunization policy and program initiatives.

The Special Projects Subcommittee will develop a white paper examining strategies for building a statewide vaccine purchasing system for all Colorado children.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	29	28	24	23.5	23
Annual Indicator	25.9	24.6	24.8	23.8	23.7
Numerator	2439	2304	2357	2281	2312
Denominator	94120	93810	94969	96001	97617
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	22	21.5	21	20.5	20

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

Notes - 2005
Data shown for reporting year 2005 are calendar 2004 data.

a. Last Year's Accomplishments
The 2007 target was 23.0 births per 1,000 teens in the age group. The target was nearly met with 23.7 births per 1,000 teens achieved.

Governor Ritter made an explicit commitment to family planning in "The Colorado Promise" and this strategic plan for the state has provided important support to decrease unintended pregnancy.

The Title X Family Planning program continued to provide contraceptive services statewide. The Latina Teen Fertility Steering Committee has been renamed Amor y Futuro and is a community advisory group to the Colorado Organization on Adolescent Pregnancy, Parenting and Prevention (COAPPP). This project no longer receives MCH funding and was successfully transferred to COAPPP.

The Colorado Abstinence Education Program continued its three-pronged approach to program

implementation: community-based programs, social marketing, and community education. Title V MCH funding provided support to school based health centers, which address high-risk behavior among teens.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Title X Family Planning program continued to provide contraceptive services statewide.	X	X	X	X
2. The Colorado Abstinence Education Program continued its three-pronged approach to program implementation: community-based programs, social marketing, and community education.	X	X	X	X
3. Title V MCH funding provided support to school based health centers, which address high-risk behavior among teens.	X	X	X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Colorado did not reapply for federal funding for the Title V, Section 510 Abstinence Education program and the program has been discontinued at the department.

The Women's Health Unit continued to work closely with the the state Medicaid Program to complete a Medicaid 1115 Family Planning Waiver to serve more low-income people.

The Family Planning Program was selected to receive substantial funding from a private foundation to expand clinical services and provide long term efficacious contraceptives to men and women in Colorado. These efforts will include outreach to teens and clients of all ages with the goal of decreasing unintended pregnancies in Colorado.

The Adolescent Sexual Health workgroup was initiated and members share information and work together around relevant issues.

A team from Colorado has been selected to participate in the Moving from Interest to Action Initiative sponsored by AMCHP and NACCHO to address teen pregnancy and/or teen HIV/STI infection at the local level.

The legislature passed House Bill 1292, establishing standards for local school districts to use when developing comprehensive and medically accurate sex-education curricula.

In August, COAPPP was awarded a two-year grant to provide teen pregnancy prevention health education through School Based Health Centers at three identified high-risk schools.

c. Plan for the Coming Year

Initiatives will continue to implement Colorado House Bill 1292, establishing standards for local school districts to use when developing sex-education curricula.

Women's Health staff members, in partnership with CASH and the Adolescent Council on Adolescent Health will develop an MCH Action Guide on Teen Pregnancy Prevention. The guide to assist local agencies with best practices information and use data to develop effective strategies. The Action Guide will be completed in March 2009.

COAPPP will continue to implement the two-year grant to provide teen pregnancy prevention health education through the School Based Health Centers at three identified high-risk schools. Two new programs "Self Center" and "Reproductive Young Men" will be adapted and implemented. These two programs more specifically address middle school health education needs, as well as increasing male involvement in pregnancy/Sexual Transmitted Infection prevention.

The Women's Health Unit will continue to work with the Colorado Department of Health Care Policy and Financing (HCPF) as the application for a Medicaid 1115 Family Planning Waiver proceeds. If the waiver is approved, a significantly increased number of low-income women and men over age 18 will be covered for family planning services through Medicaid. Extensive outreach to healthcare providers and consumers is planned to implement the waiver after it is approved. The implementation plan will include education for healthcare providers, establishing the system for determining eligibility and enrollment of clients, and social marketing regarding services available.

A workgroup for Adolescent Sexual Health will continue with members from Women's Health unit, Child Adolescent and School Health unit, Colorado Department of Education, and COAPPP.

Recommendations will be reviewed from the Colorado team participating in the AMCHP and NACCHO "Moving from Interest to Action Initiative" to address teen pregnancy and/or teen sexually transmitted infections at the community level. Selected recommendations will be implemented given the availability of sufficient resources.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	35	35	35.5	35.5	36
Annual Indicator	29.3	35.2	35.2	29.3	35
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	36	40	40	41	41.5

Notes - 2007
Data reported for 2007 are final Basic Screening Survey data from the 2006-2007 school year for a representative sample of 3rd graders.

Notes - 2006
Data reported for 2006 are preliminary Basic Screening Survey data from the 2006-2007 school year. When finalized, a representative sample of 3rd grades will be covered. Preliminary data were not yet weighted or fully analyzed when these data were submitted in July 2007.

Notes - 2005
Data reported for 2005 are 2003-2004 school year data reported for 2004 as well.

a. Last Year's Accomplishments
The 2007 target was 36 percent. The target was not met with 35 percent acheived.

To address sustainability of the sealant program, contractors were urged to submit for Medicaid reimbursement to supplement grant funding. In April 2008, training was held for sealant contractors on how to bill Medicaid. Staff from the Department of Health Care Policy and Financing provided the training. Sealant contractors reviewed a sample billing and were coached on completing the form.

The Colorado Sealant Program initiated a project to document the number of referrals made and kept for dental care generated from sealant screenings. The Oral Health Unit tracked successful referrals to dental care through the SEALS software. Results can be found at the CDPHE, Oral Health Unit's webpage at http://www.cdphe.state.co.us/pp/oralhealth/OralHealth.html

When the HRSA State Oral Health Collaborative Systems grant ended, Colorado received one of 20 HRSA Targeted Oral Health Service Systems grants. This grant allows the Unit to expand the sealant program. The four-year grant also focuses on increasing the number of children with dental homes.

The Oral Health Unit continued to wait for the release of the CDC's Sealant Expert recommendations for improving the operations and support of school-based sealant programs. The CDC held up their release of the recommendation until another expert panel, convened by the American Dental Association (ADA), completed their work on sealants. The ADA published their sealant recommendations in the April issue of the Journal of the American Dental Association. The CDC released their recommendations at the 2008 National Oral Health Conference. The Oral Health Unit distributed the CDC recommendation to all Colorado public and private practice settings, including school sealant program contractors.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expanded the school-based oral sealant program.	X		X	X
2. Provided technical assistance and training regarding sealants.			X	
3. Collected, analysed and posted oral health information.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Previously described activities continued.

Sealant program,contractors were asked to submit for Medicaid reimbursement to supplement grant funding. In April training was held for sealant contractors on how to bill Medicaid conducted by state Medicaid staff.

The Colorado Sealant Program initiated a project to document the number of referrals made and kept for dental care generated from sealant screenings. The Oral Health Unit tracked successful referrals to dental care through the SEALS software. Results can be found at the CDPHE, Oral Health Unit's webpage at http://www.cdphe.state.co.us/pp/oralhealth/OralHealth.html.

When the HRSA State Oral Health Collaborative Systems grant ended, Colorado received one of 20 HRSA Targeted Oral Health Service Systems grants. This grant allows the Unit to expand the sealant program. The four-year grant also focuses on increasing the number of children with dental homes.

The CDC's Sealant Expert recommendations for improving the operations and support of school-based sealant programs were delayed until the release of recommendation from an American Dental Association expert pane. The Oral Health Unit distributed the CDC recommendation to all Colorado public and private practice settings, including school sealant program contractors.

c. Plan for the Coming Year
Activities described previously will continue.

The Oral Health Unit will finalize the evaluation of the school-based sealant program using SEALS data for the three-year period (2004-2007). The evaluation will provide data for the Oral Health Unit to use for expansion efforts; for marketing the program to additional contractors; and to document success for potential funders.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	3.5	3.3	3	3	3
Annual Indicator	4.4	4.2	3.4	3.2	3.2
Numerator	42	41	33	32	32
Denominator	955587	966203	970051	989454	1002764
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	3	2.5	2.4	2.4	2.3

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

Notes - 2005
Data shown for reporting year 2005 are calendar 2004 data.

a. Last Year's Accomplishments
The FY 2007 target was 3.0 deaths per 100,000 children. The measure was nearly met with 3.2 deaths per 100,000 children achieved.

Injury, Suicide and Violence Prevention (ISVP) staff worked on the CDC-funded community-based intervention project. The project targeted childcare centers in Colorado Springs to reach parents and children with the booster seat message. The seatbelt coalitions in Delta and Prowers counties include child passenger safety messages in their programs. The results of these efforts were submitted to peer-reviewed publications, and the information was provided to local health agencies and the public through the state health department.

The study found that a childcare center-based program emphasizing staff education and booster seat distribution increased parents' receipt of information and their knowledge, but did not increase booster seat use. Booster seat outcomes were significantly lower among children riding in pick-up trucks or with Hispanic or black drivers, indicating the need for research to understand how to reach at risk populations.

Work continued with the Colorado Department of Transportation statewide Child Passenger Safety (CPS) program to support training of more Child Passenger Safety Technicians and to develop local CPS programs through participation on the state CPS Board. Additional strategies that have been identified in support of the Injury Strategic Plan included increasing the involvement of hospitals and communities in injury prevention programs such as child passenger safety.

Safe Kids Colorado (state coalition) formed a Safe Kids Chapter in Mesa County.

CDPHE transferred its role as lead agency for the state Safe Kids Coalition to The Children's Hospital in Denver.

A primary seatbelt bill (SB07-151) was proposed during the state legislative session to increase the age for booster seats from 6 to 8 years old and increase the height from 55" to 57". It was defeated by one vote.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued training and expansion activities.	X	X	X	X
2. Work continued with the Colorado Department of Transportation statewide Child Passenger Safety (CPS) program to support training of more Child Passenger Safety Technicians and to develop local CPS programs through participation on the state CPS Board				X
3. Formed a Safe Kids Colorado Chapter in Mesa County.			X	
4. CDPHE transferred its role as lead agency for the state Safe Kids Coalition to the Children's Hospital in Denver.				X
5. Supported primary seatbelt legislation, which included strengthening the booster seat law (defeated by one vote).				X

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Results from the booster seat project in Colorado Springs identified that childcare center regulation regarding transportation of children could be strengthened. A sample Family Transportation Agreement for childcare centers to use with the families they serve was developed. This agreement explained CPS laws and stresses best practice for transporting children. It is posted at http://www.cdphe.state.co.us/pp/injuryprevention/CCCFamilyTransportationAgreement.pdf.

ISVP staff assisted Emergency Medical Services in promoting Provider Grant opportunities to communities around the state. Two communities submitted applications to strengthen their CPS program. ISVP staff also continued to serve on the state CPS advisory board and helped to promote other local CPS grant opportunities available from the Department of Transportation.

ISVP staff, in conjunction with the Injury Community Planning Group (ICPG), continued to promote seatbelt use for all occupants of motor vehicles. Studies have shown that when drivers wear seatbelts, the children in the vehicle are more likely to be restrained. ISVP staff and ICPG workgroups revised the motor vehicle chapter of the State Injury Prevention Strategic Plan.

The Colorado State Patrol and the Colorado Department of Transportation partnered to conduct focus groups with "tweens" (8-15 year olds) to assist in developing a social marketing campaign to increase seatbelt use in this age group

c. Plan for the Coming Year
ISVP and ICPG will continue to promote seatbelt use for all occupants of motor vehicles and will monitor any seatbelt or CPS legislation, if proposed, for the 2009 legislative session.

ISVP will support local communities that are implementing programs to increase motor vehicle safety for 0-14 year olds by providing and coordinating technical assistance and developing other resources that support community review of evidence-based programs, policy options and practices. ISVP staff will develop four fact sheets on childhood injury topics, including motor vehicle safety. The Program will also support the Department of Transportation's "Tween" Motor Vehicle Safety social marketing campaign that is being developed.

ISVP staff will continue to serve as a board member on the State CPS Advisory Board. ISVP staff and other CPS Advisory Board members will partner with the Colorado Department of Human Services to propose strengthening the Childcare Center Regulations by including updated CPS statue information and requiring child care centers to include the Family Transportation Agreement in their parent handbooks.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				42	47
Annual Indicator			41.5	46.3	42

Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	43	45	50	50	50

Notes - 2007
Data shown for 2007 are breastfeeding data collected by the National Immunization Survey for infants born in 2004. This method represents a change from the methodology of previous NIS surveys, where the data pertained to the year the interview occurred -- which was not necessarily the birth year of the infant.

Notes - 2006
Data shown for 2006 are breastfeeding data collected by the National Immunization Survey in 2005.

Notes - 2005
Data shown for 2005 are National Immunization Survey data for 2004.

a. Last Year's Accomplishments
The target for breastfeeding duration for 2007 was raised to 47.0 percent of mothers breastfeeding their infants at six months. The 2007 National Immunization Survey indicated that among Colorado mothers who initiated breastfeeding in 2004, 42.0 percent were breastfeeding their infants at 6 months of age. This rate cannot be compared with previous years as the survey source has changed (see note above). The 2007 target was unmet, although the most recent available data is from 2004.

Colorado continued to analyze sources of data to determine which represents the most accurate evaluation of breastfeeding duration. The Colorado Child Health survey was revised and the breastfeeding questions were expanded to collect data on exclusive breastfeeding, limited to mothers of 12-35 month-old children. This age range includes children younger than those included in the National Immunization Survey and may result in more accurate reporting of breastfeeding continuation experiences.

During the past fiscal year, Colorado expanded support for mothers to enable them to breastfeed longer. The Colorado WIC Program, where data has been measured and consistently reported, shows improvement in six-month breastfeeding rates from 2003 (26.9%) to 2004 (27.2%) and 2005 (28.5%). The WIC Program provided breastfeeding education and support to all pregnant and breastfeeding participants.

The state health department disseminated statewide and nationally the report, Getting It Right After Delivery: Five Hospital Practices That Support Breastfeeding, (www.cdphe.state.co.us/ps/mch/gettingitright.pdf). This report emphasized the importance of a combination of five specific hospital practices that, when implemented, significantly improve the length of time women breastfeed. The practices are: breastfeeding in the first hour after birth; infants staying in the same room as their mothers; infants fed only breast milk and receiving no supplements; no pacifier use; and mothers receive a telephone number to call for breastfeeding help. The authors of the report presented the findings to various audiences including health care and public health professionals. The findings were also published in the September 2007 issue of Birth: Issues in Perinatal Care. (attachment)

The Colorado Physical Activity and Nutrition Program (COPAN) funded several locally-based breastfeeding projects that promoted community and hospital collaboration to build breastfeeding support. One project contracted with two lactation experts to provide technical assistance to several hospitals located in counties with lower breastfeeding rates. The assistance included workshops and training on breastfeeding promotion and management. The experts also worked with hospitals to perform an assessment of their support of breastfeeding and to assist in the development of supportive breastfeeding policies. As a result, four hospitals instituted new policies to support breastfeeding. COPAN conducted a worksite lactation support survey of 1,400 businesses statewide. The coalition then awarded and recognized 37 businesses and organizations that provide supportive environments and practices for employed breastfeeding mothers. The state health department joined the list this year with the release of a new policy that promotes an environment where breastfeeding is supported and provisions are made for mothers who choose to continue to offer breast milk to their infant after returning to work at the department or who are visiting the department on official business.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Colorado continued to analyze and report sources of data.				X
2. The Colorado Child Health survey was revised and the breastfeeding questions were expanded to collect data on exclusive breastfeeding, limited to mothers of 12-35 month-old children.				X
3. Disseminated statewide and nationally the report, Getting It Right After Delivery: Five Hospital Practices That Support Breastfeeding.				X
4. Continued coalition activities to support and promote breastfeeding.	X	X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The results and findings of the Colorado Breastfeeding report were disseminated. Staff from the Colorado Breastfeeding Taskforce developed a presentation and a companion hospital resource kit to accompany the report. Volunteer WIC and taskforce staff used the presentation when meeting with hospital representatives. Nearly half of Colorado's hospitals received a resource kit.

COPAN hosted several volunteer trainings about how to deliver the PowerPoint presentation and tips for contacting key hospital staff. COPAN members were available to provide follow-up technical assistance.

Members of the Breastfeeding Taskforce promoted the five breastfeeding support practices to Colorado families, particularly pregnant women. The WIC Program and the Breastfeeding Taskforce created a crib card to support mothers in requesting the five practices in the hospital to get breastfeeding right from the start. WIC staff received the crib cards and were training on the five practices.

WIC staff worked with Metropolitan State College of Denver to develop an educational credit

course for nurses on breastfeeding.

HB 1276, the Workplace Accommodations for Nursing Mothers Act passed that supported workplace accommodations for breastfeeding mothers. The Taskforce began planning how to provide guidance to employers regarding this legislation.

One hundred WIC professional and paraprofessional staff attended a three-day training to become lactation specialists.

c. Plan for the Coming Year

By the end of the calendar year, the majority of Colorado hospitals will have been contacted by a lactation expert volunteer and will have received a hospital resource kit. By 2010, Colorado will be able to evaluate this intervention by measuring the number of hospitals that are implementing the five practices, compare this data to the responses of mothers about their hospital experiences, and compare these findings to information collected in years 2003-2005. The taskforce and the state health department are considering providing awards to hospitals that adopt the five practices.

Collaborative efforts between COPAN and the Breastfeeding Taskforce will continue to address support of breastfeeding in the workplace. The Taskforce will make technical assistance available to employers as they implement the new legislation described above.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	95	95	98	98	98
Annual Indicator	96.2	97.2	97.5	97.5	97.6
Numerator	65839	67329	66769	66912	68282
Denominator	68465	69304	68475	68660	69939
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	98	98	98	98	98

Notes - 2007

Data shown for reporting year 2007 are calendar year 2006 data.

The numerator is the number of newborns that underwent the newborn hearing screening at birth who were born to Colorado residents who delivered in Colorado. The denominator is the number of live births to Colorado residents who gave birth in Colorado. (The denominator is smaller than the total number of births to Colorado residents by the number of residents who gave birth out-of-state.)

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

The numerator is the number of newborns that underwent the newborn hearing screening at birth who were born to Colorado residents who delivered in Colorado. The denominator is the number of live births to Colorado residents who gave birth in Colorado. (The denominator is smaller than the total number of births to Colorado residents by the number of residents who gave birth out-of-state.)

Notes - 2005
Data shown for reporting year 2005 are calendar 2004 data.

a. Last Year's Accomplishments
The 2007 target was 98 percent. The target was nearly met with the actual being 97.6 percent.

The state Early Hearing Detection and Intervention (EHDI) program completed a comprehensive analysis of the Newborn Hearing Screening program and identified two specific populations, infants in the NICU and infants who are Hispanic, that are missed for their initial or follow-up hearing screen more frequently than other populations. Information gathered through this analysis allowed the EHDI program to develop strategies targeting the parents of these specific groups of infants.

The state EHDI staff began meeting more regularly with birth hospitals across the state to provide technical assistance and support on an individual hospital level.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Completed a comprehensive analysis of the Newborn Hearing Screening program.				X
2. Develop strategies for better targeting the parents.			X	
3. Ensured screening of all newborns for the 29 conditions.	X	X	X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Previous activities described above will continue.

Regional EHDI teams were established throughout Colorado. Each EHDI team is comprised of the local Audiology Regional Coordinator, the county Healthcare Program for Children with Special Needs Team Leader, the regional Colorado Hearing Resource Coordinator, a local parent of a child with hearing loss involved with the Hands & Voices support group, local birth hospital coordinator(s), and other key stakeholders in the community. The teams provided training for each birthing hospital. They also identified and addressed gaps specific to each community. When a need was identified, the NICU Liaison participated on the EHDI team to address screening needs specific to the NICU.

Colorado has been awarded an MCHB EHDI Grant to implement medical home concepts into

EHDI systems.

Colorado is one of five states participating in the National Initiative for Children's Healthcare Quality (NICHQ) learning collaborative. NICHQ is funded through the Maternal Child Health Bureau. The learning collaborative provides a unique opportunity for Colorado's improvement team to share, test, and implement ideas for more timely, appropriate, coordinated, and family-centered care for children identified with hearing loss. The Colorado team consists of seven members, state and clinical partners, as well as the parent of a child who is deaf.

c. Plan for the Coming Year

The EHDI program will continue to work closely with the state health department's Laboratory Services Division to integrate data from the newborn metabolic screen, the newborn hearing screen, and the electronic birth certificate. More complete data integration will allow the EHDI program to obtain the name of an infant's primary care physician and ensure (s)he is made aware on the infant's hearing screening results. Additionally, the child's medical home will be involved to ensure follow-up and diagnostic procedures are completed in a timely manner when necessary.

The state EHDI program will use the state health department's newly acquired Webinar technology to hold video and web conferences with birth hospital screening staff throughout the state. This meeting format will lead to uniform and timely dissemination of important screening-related information and allow hospital staff to interact with the presenter and each other in real time. These opportunities were previously unavailable due to the high cost and logistics of coordinating a face-to-face meeting. A Webinar will be planned to meet the needs of the hospital screening coordinators in rural Colorado.

The IDS database system will be converted from a CITRIX-based system to a web-based system. The database is populated by the electronic birth certificate and is used to follow children who missed or failed their initial hospital hearing screen. This improvement will allow easier access by all IDS users and will enable more hospitals and audiologists to securely access and input newborn screening and diagnostic data directly into the database.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	15	15	15	10	9
Annual Indicator	15.1	14.3	12.6	11.9	10.3
Numerator	184272	176328			
Denominator	1220344	1233064			
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	10	9	8	8	7

Notes - 2007
Data shown for 2007 are calendar year 2007 Colorado Child Health Survey data. The percentage includes children age 1-14 uninsured at the time of the survey.

Notes - 2006
Data shown for 2006 are calendar year 2006 Colorado Child Health Survey data. The percentage includes children age 1-14 uninsured at the time of the survey.

Notes - 2005
Data shown for 2005 are calendar year 2005 Colorado Child Health Survey data. The percentage includes children age 1-14 uninsured at the time of the survey. Data shown in previous years were American Academy of Pediatrics estimates, which include all children 19 and under.

a. Last Year's Accomplishments
The target for 2007 was set at 9.0 percent. Calendar year 2006 data from the Colorado Child Health Survey show a rate of 10.2 percent, not meeting the target. While the change from 2006 is not statistically significant, the data show a continuing downward trend since the statewide survey was begun in 2004 from 12.6 to 11.9 to 10.2.

During the past fiscal year, the Colorado Covering Kids and Families Initiative, funded by the Robert Wood Johnson Foundation, worked to enroll all eligible children and adults in public insurance programs. Efforts continued to simplify enrollment processes (applications are now available on-line) and to increase retention.

Income guidelines for the Child Health Plan Plus (CHP+) increased on July 1, 2005 to cover children and pregnant women whose incomes were at or below 200 percent of the federal poverty guideline, up from 185 percent previously. Marketing efforts were expanded and six regional outreach coordinators hired. These coordinators conducted presentations for community-based and professional organizations, physicians and families, partnering with key community stakeholders, especially those involved with school-based health.

A marketing and outreach plan was also developed. It included regional media and advertising in Spanish and English. Newsletters to community-based organizations were reinstated and new family-friendly marketing materials, a desk guide for professionals, and a website update were also implemented. Applications can be downloaded in Spanish and English at www.cchp.org.

A number of changes incorporating the eligibility expansions were made to the Colorado Benefits Management System.

The assets test was eliminated that excluded persons from Medicaid eligibility if they had more than $2,000 in assets (including a car) on July 1, 2006. The removal of the assets test helped many more people qualify for coverage.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participated in the Colorado Covering Kids and Families Initiative.				X
2. Marketing efforts for public insurance programs were expanded and six regional outreach coordinators hired.				X
3. A marketing and outreach plan was also developed.			X	X
4. An online Medicaid and CHP+ application is available.	X			
5. Participated in activities to increase awareness of new laws	X	X	X	X

streamlining efforts to enroll in Medicaid and CHP+.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Based on legislation passed in the 2007 Colorado legislative session, MCH is working closely with the Colorado Department of Health Care Policy and Financing, through the Medical Home Initiative, to develop state accepted standards for a medical home. In addition to key state agency representation, the Medical Home Initiative Advisory Board includes, but is not limited to, participation from the Colorado Chapter of the American Academy of Pediatrics, the Colorado Academy of Family Physicians, family representatives, mental health and oral health representatives.

Access to care remains an important public health assurance function and an MCH essential service. Several local agencies have identified these activities as a priority area. MCH created an Access to Care Workgroup with local public health MCH contractors and state staff to explore local health departments' reasons for investing in efforts to address access to care at the enabling services level (e.g., the provision of individual presumptive eligibility certification services). The group will determine if efforts might be more effectively employed at the infrastructure building versus the enabling service level. They will also develop evaluation expectations.

Several important bills passed that are summarized in the legislative update within the Agency Capacity Section.

c. Plan for the Coming Year

The 2008 legislative changes coupled with the continued momentum around addressing access to health care issues through the Medical Home Initiative provide a promising environment for meeting the 2009 goal.

The Medical Home Initiative will continue to refine and finalize standards for medical homes. The Medical Home Initiative has applied for two different grants to help support technical assistance to assist providers in meeting the identified standards and promote the medical home approach.

The MCH Access to Care work group will continue their work over the next year, focusing on the development of strategies to evaluate the impact of these enabling service-focused access to care activities on the MCH performance measures.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				24	24
Annual Indicator			24.2	24.7	24.3
Numerator			8739	8832	9825
Denominator			36113	35758	40432
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	24	23	23	22	22

Notes - 2007
Data shown for 2007 are from the 2006 Pediatric Nutrition Survey.

Notes - 2006
Data shown for 2006 are from the 2005 Pediatric Nutrition Survey.

Notes - 2005
Data shown for 2005 are from the 2004 Pediatric Nutrition Survey.

a. Last Year's Accomplishments
The 2007 target was 24 percent. The measure was nearly met with 24.3 percent achieved.

A Value Enhanced Nutrition Assessment (VENA) Advisory Committee was convened composed of state and local agency experts. The purpose was to strengthen WIC's assessment, counseling and goal setting protocols to improve the effectiveness of WIC services at the community level.

The May 2007 Colorado WIC Program's Annual Meeting‘s program included a wide variety of presentations intended to improve staffs' understanding of the factors associated with childhood overweight, as well as strengthening the ability of WIC nutrition counselors to address the issue.

Colorado WIC staff participated on Colorado Physical Activity and Nutrition's (COPAN) Early Childhood Taskforce and on COPAN's Breastfeeding Taskforce to jointly address these issues.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Convened an advisory committee to strengthen the effectiveness of WIC services				X
2. The WIC Annual meeting addressed the factors influencing childhood overweight and interventions.				X
3. Continued to work COPAN and others to address this issue.	X	X	X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Colorado WIC Program conducted a WIC Participant Satisfaction Survey in Spanish and English that asked participants questions regarding their own assessment of their child's weight. Survey summary reports were provided to agencies and will be used in future planning.

WIC implemented new policies and provided training to enhance the competency of WIC staff in

conducting participant-centered WIC visits. These efforts enhanced staff's effectiveness when discussing sensitive topics such as weight. Regional Workshops addressed participant-centered nutrition assessment, counseling and goal setting. These trainings offered examples of assessment, counseling and goal setting strategies to use with overweight WIC participants.

WIC Program Staff participated in the COPAN Early Childhood Taskforce and the Breastfeeding Taskforce, both of which addressed childhood obesity.

USDA issued the final interim rule for WIC food packages revisions. The State WIC Office planned for the implementation of the revised WIC food package.

A staff position is being considered that will coordinate breastfeeding promotion and support activities across the WIC, COPAN, and MCH Programs.

A position paper, "The Role of the Colorado WIC Program in the Prevention of Maternal and Pediatric Overweight and Obesity" is under development. It is intended to be a resource to for WIC staff regarding their roles in preventing maternal and childhood overweight.

c. Plan for the Coming Year

Prevention of overweight is one of two statewide health outcome goals that are included in Colorado WIC's new Nutrition Education Plan. Each local WIC agency will assist in achieving the statewide goal by developing and implementing community-specific actions plans targeting overweight prevention and breastfeeding promotion. The nutrition education planning process includes conducting a needs assessment; developing an action plan that includes evaluation activities; and reporting these activities to the State Office.

Colorado will implement the new food package rule by October 2009. These food package changes include: the addition of fresh fruits and vegetables; reduction in the amount of juice given to infants; and inclusion of whole grains. These positive changes will complement WIC's ongoing message about healthy eating.

A staff position to address childhood overweight issues across the WIC, COPAN, and MCH Programs will be considered. If created, this position will coordinate efforts across the department to enhance healthy weight among children.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				10	9
Annual Indicator			10.4	10.2	10.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	10	9	8	7	7

Notes - 2007
Data for reporting year 2007 are from 2006 Pregnancy Risk Assessment Monitoring System (PRAMS) data.

Notes - 2006
Data for reporting year 2006 are from 2005 Pregnancy Risk Assessment Monitoring System (PRAMS) data.

Notes - 2005
Data shown for reporting year 2005 are 2004 Colorado PRAMS survey data.

a. Last Year's Accomplishments
The 2007 target was 9.0 percent. This measure was not met with 10.4 percent acheived.

For local health agencies implementing the "Healthy Baby Campaign", the health care provider training was refined to integrate prenatal weight gain and smoking cessation strategies. A statewide training for MCH contractors was held in November. A consumer-based outreach strategy developed for local MCH contractors about prenatal weight gain and smoking cessation for pregnant women. This activity involved a key informant interview and community action team process which identified ways to reach pregnant women.

Members of the MCH staff served on a State Tobacco Education and Prevention Partnership (STEPP) media committee to develop materials targeting low-income women who smoke. The campaign goal was to get pregnant women who smoke to call the QuitLine for professional coaching and guidance to quit. Focus groups, composed of pregnant women who smoke, provided guidance in message development that would encourage women to call the QuitLine. Posters, brochures and "mommy" kits were developed for distribution in public health and safety net clinics statewide.

The Baby and Me Tobacco program was piloted by Mesa County using MCH and March of Dimes funding. The project piloted a diaper incentive program for low-income women who completed a smoking cessation program during pregnancy. Diaper vouchers were given monthly to eligible women who successfully completed the smoking cessation program and who participated in monthly carbon dioxide monitoring for up to one year postpartum.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Healthy Baby Campaign's health care provider training was refined to integrate prenatal weight gain and smoking cessation strategies.				X
2. Served on the State Tobacco Education and Prevention Partnership (STEPP) media committee to develop materials targeting low-income women who smoke.				X
3. Participated in the development and funding of the Mesa County Baby and Me Tobacco Free Program.	X	X	X	
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
Prenatal smoking cessation strategies were incorporated with appropriate weight gain strategies into a MCH Healthy Baby Action Guide.

Ten local health agencies used Healthy Baby strategies in their MCH implementation plans.

An external advisory group was formed to strengthen prenatal smoking cessation messages. Colorado Clinical Guidelines Collaborative (CCGC), State Tobacco Education and Prevention Partnership (STEPP) and the Women's Health Unit are leading the organizational efforts. The panel will develop a consensus statement and messaging specific to prenatal smoking cessation.

A division-wide effort was convened to address prenatal smoking cessation among WIC, STEPP, Prenatal Plus, and the Nurse Family Partnership.

The STEPP grant process continued to fund outreach to women of reproductive age. The Colorado QuitLine provides coaching services and free nicotine replacement therapy, with a doctor's prescription, to Colorado residents calling into the phone line.

The Colorado Clinical Guidelines Collaborative, using STEPP funding, funded two prenatal offices to develop evidence-based smoking cessation interventions.

WIC, Nurse Family Partnership, Prenatal Plus and Family Planning programs continued prenatal smoking cessation efforts.

c. Plan for the Coming Year
Once the Colorado statewide consensus statement and Prevention Service's Division project team recommendations are complete, they will be integrated into division and state plans to more fully address the issue of prenatal smoking cessation.

Community-level MCH plans will continue to incorporate prenatal smoking cessation messages with appropriate weight gain recommendations to help reduce Colorado's low birthweight rate. The newly developed Healthy Baby Action Guide and other Healthy Baby resources will be made available.

It is anticipated STEPP's media campaigns will continue and may expand.

The Family Planning, Nurse Family Partnership and WIC programs will continue prenatal smoking cessation efforts.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	13	12.5	12	11.5	11
Annual Indicator	13.6	7.3	13.7	14.6	10.8
Numerator	46	25	47	51	38
Denominator	337039	341560	342486	348573	352852
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	10.5	10	9.5	9	8.5

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

Notes - 2005
Data shown for reporting year 2005 are calendar 2004 data.

a. Last Year's Accomplishments
The 2007 target was 11.0 deaths per 100,000 teens age 15-19. The target was met with a rate of 10.8 deaths per 100,000 teens.

Suicide remained the second leading cause of death among youth ages 10-24 in Colorado. Based on death certificate data from 1997-2006, the ten-year annual average suicide rate for young adults ages 15-19 in Colorado was 12.6 per 100,000, more than twice the Healthy People 2010 goal of 5.0 per 100,000 for all ages. Ten of Colorado's 64 counties have a youth suicide rate that is statistically higher than the 2002 national rate of 6.9 per 100,000.

The Office of Suicide Prevention coordinated a number of programs from October 2006 through September 2007. The Office provided more than 20,000 pieces of public awareness materials regarding suicide and suicide prevention to individuals and organizations in every region of the state. The Office, in partnership with the Suicide Prevention Coalition of Colorado, held four town hall meetings to foster strong collaboration and coordination with local suicide prevention efforts. Meetings were held for interested residents in Yuma, Eagle, Park and Las Animas counties. Youth suicide prevention was a component of discussion at each town hall meeting.

Grants were provided from the Office of Suicide Prevention to ten local agencies for suicide prevention and education services. Local grantees used funds for a variety of youth-focused activities including: increasing community awareness of suicide prevention resources; community coalition development; suicide prevention programming at Regis University in Denver; suicide prevention training for Native American's and Native American youth; and, suicide prevention for adults working with gay, lesbian, bisexual, transgender and questioning youth.

The Office provided financial support to the 1-800-273-TALK crisis line for infrastructure and data collection, and to the Suicide Prevention Coalition of Colorado to conduct regional town hall meetings, public awareness campaigns, and advocacy training. The Office sponsored an evaluation of the Yellow Ribbon Suicide Prevention Program, a school-based suicide prevention program, through a partnership with the University of Denver and the Yellow Ribbon Program. The Office also partnered with the American Foundation for Suicide Prevention to disseminate public service announcements targeting adolescent suicide and suicide prevention to every television and radio outlet in Colorado.

The Office of Suicide Prevention strengthened key private and public partnerships through participation on statewide committees including: the Colorado Child Fatality Review; the Injury Community Planning Group; the Colorado Violent Death Reporting System Advisory Committee; the Violence Prevention Advisory Group; and the Interagency School Health Team. These

partnerships resulted in the coordination of prevention recommendations, data collection, and service delivery from state agencies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distributed public awareness materials statewide.		X		
2. The Office, in partnership with the Suicide Prevention Coalition of Colorado, held four town hall meetings to foster strong collaboration and coordination with local suicide prevention efforts.			X	
3. The Office provided financial support for resources to support suicide prevention efforts.				X
4. The Office sponsored an evaluation of the Yellow Ribbon Suicide Prevention Program.				X
5. Participated in relevant statewide coalitions.				X
6. Grants were provided to ten local agencies for suicide prevention and education services.	X	X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

State funding of $286,000 was allocated for suicide prevention programs for state fiscal year 2008, which began July 1, 2007. Activities included co-sponsoring with the Suicide Prevention Coalition of Colorado town hall meetings to assess local needs in targeted Colorado regions.

The Office worked with The Colorado Trust Foundation, Mental Health America of Colorado, and the Suicide Prevention Coalition of Colorado to begin developing a new statewide strategic plan for suicide prevention. As part of the plan development process, five regional meetings were held throughout Colorado to gather statewide stakeholder input. Meetings were held in Weld, Mesa, Montezuma, Pueblo and Denver counties, with more than 250 total participants.

Other activities include the coordination of statewide efforts such as: a public awareness campaign directed to teens; suicide prevention efforts in five Colorado counties and at the University of Colorado at Boulder; evaluating the Yellow Ribbon school-based suicide prevention program at two Denver area high schools; ensuring that the 1-800-273-TALK crisis hotline is operational 24 hours per day, seven days per week; and continuing to disseminate community grants dedicated to suicide prevention across the state.

c. Plan for the Coming Year

The Office of Suicide prevention will continue to implement the initiatives referenced above.

Activities will include continuing to coordinate statewide efforts such as a public awareness campaign directed to teens; continue implementing suicide prevention efforts in five Colorado counties and at the University of Colorado at Boulder; evaluating the SAFE:TEEN school-based suicide prevention program at two pilot schools in Colorado; and continuing to disseminate community grants dedicated to suicide prevention across the state. State funding of $286,000 is allocated for suicide prevention programs for the coming fiscal year.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	75	75	75	80	83
Annual Indicator	74.6	73.5	71.9	68.6	81.4
Numerator	672	666	639	619	725
Denominator	901	906	889	902	891
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	85	87	90	90	90

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

Notes - 2005
Data shown for reporting year 2005 are calendar 2004 data.

a. Last Year's Accomplishments
The 2007 target was 83.0 percent The target was not met as the actual measure was 81.4 percent.

As of 6.1.06, a total of 17 hospitals where births occur were considered to be Level III--eight are Level IIIA, seven are Level IIIB, one is Level IIIC and one is Level III undesignated. These numbers compare to a total of eight hospitals that were Level III before the redesignation took place. The designated hospitals have increased the proportion of all very low birth weight births born in appropriate facilities to 81.4 percent. This change was due to the fact that a number of formerly Level II hospitals were able to upgrade their facilities to care more appropriately for their very low birth weight infants, rather than to any change in referral patterns away from Level IIs to Level IIIs.

In the American Academy of Pediatrics guidelines, issued November 2004, concerning levels of neonatal care, recommendations were made for uniform nationally applicable definitions of levels of neonatal intensive care that were based on the capability of facilities to provide an increasing complexity of level of care. In particular, distinctions were more finely drawn between Level II specialty care and Level III subspecialty care than under the old system. Level II facilities are now divided into two sublevels: IIA and IIB; care can be provided to infants born at greater than 32 weeks gestation and weighing at least 1500 grams in IIA facilities, while IIB facilities can provide mechanical ventilation for brief durations in addition to the care provided in IIAs. Level IIIs are now divided into three sublevels: IIIAs can provide comprehensive care for infants born at more than 28 weeks gestation and weighing more than 1000 grams, while IIIBs can provide care to infants at 28 weeks gestation or less and under 1000 grams, and IIICs can provide care to all infants. The distinctions between Level IIB and Level IIIA are especially important in terms of providing care to very low birth weight infants under this performance measure.

During 2005 and 2006, the Colorado Perinatal Care Council revised the hospital self-assessment tool to reflect the new guidelines and began the process of encouraging hospitals to reassess their nurseries. By the end of September 2006, many hospitals had submitted assessments that changed their status from Level II to Level III. These new designations took effect with births beginning January 2006, and the data reported for 2006 (reported in 2007 at 81.4 percent) reflects an increase in the percent of very low birth weight births being born in facilities designated as Level III.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitored data associated with this measure.				X
2. Participated in the Perinatal Care Council.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Women's Health Unit continued to monitor improvements and explored ways to increase the percentage of very low birth weight infants born in appropriate facilities by working with the Colorado Perinatal Care Council, a statewide organization committed to improving perinatal care in Colorado. A liaison was designated to participate on the Colorado Perinatal Care Council to increase information sharing, interaction and collaboration.

c. Plan for the Coming Year

The Women's Health Unit will continue to monitor this measure. A representative will continue to participate on the Colorado Perinatal Care Council.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	85	85	83	83	84
Annual Indicator	79.1	79.3	80.2	80.1	79.7
Numerator	53293	54117	53955	54147	55354
Denominator	67414	68255	67251	67639	69430
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	84	82	83	84	85

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data. Number of pregnant women whose onset of prenatal care is unknown have been excluded.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data. Number of pregnant women whose onset of prenatal care is unknown have been excluded.

Notes - 2005
Data shown for reporting year 2005 are calendar 2004 data.

a. Last Year's Accomplishments
The 2007 target for 2006 was 84.0 percent. The target was not met as the actual was 79.7. The percentage of women receiving first trimester care has varied little in the past few years, ranging between 79.1 percent and 80.7 percent.

Estimates made using month by month 2005 birth certificate data suggest that the termination of presumptive eligibility for Medicaid eligible women did have a negative impact on the overall proportion of women receiving early care. According to an analysis conducted by the MCH program the percentage of women receiving first trimester care would have been 81.1 percent for 2005, one percentage point higher than the actual level of 80.1 percent, if Medicaid had not eliminated presumptive eligibility or implemented an electronic eligibility system.

Problems associated with the Colorado Benefits Management System (CBMS) that begun in 2004 continued into this year. Local county offices reported ongoing problems with quick enrollment of pregnant women into Medicaid.

The Learning Community on Preconception and Prenatal Health focused on promising practices and examined evidenced-based approaches to prenatal care. A presentation of the "Centering Pregnancy" group model for prenatal care was held. The forum also hosted a web cast presentation in November on "An Evidenced Based Approach to Prenatal Care" by Michael Policar MD, Associate Professor of Obstetrics and Gynecology at the University of California at San Francisco. Ninety participants registered to watch on 57 computers throughout the Colorado. One-third of the live audiences were clinical health care providers and the remaining were public health providers.

Dr. Policar's presentation suggested that there are a number of prenatal care practices that are of questionable value, along with some that should be continued. Several effective interventions are under performed (e.g., smoking cessation counseling). Studies show that a reduced number of visits demonstrated no difference in outcomes. Preconception planning is key. A menu of options needs to be created regarding the number and content of prenatal care visits that fit with women's overall mental, physical health, family and social support. The need to address known risk factors that adversely impact birth outcomes such as smoking and inadequate nutrition with education, case management outreach, and social support are needed. Finally, the most important time to address risk factors is in the preconception timeframe, yet there are few evidence-based models to implement and no reimbursement available through insurance. The overall conclusion from the webcast along with the state's experience is that first trimester enrollment as a benchmark of prenatal health may not be meaningful and this information has been used as part of the WH Prenatal strategic planning process.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitored and reviewed factors associated with this measure.				X
2. The Learning Community on First Trimester Care continued meeting.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Problems with CBMS and the determination of eligibility for Medicaid coverage continued to impact birth statistics for 2006 and 2007. However, the positive impact of new funding available for prenatal care somewhat counteracted the negative impact of system problems. The approval of the State's Amendment 35 in 2004 allowed the expansion of prenatal care coverage for women in the Child Health Plan Plus (CHP+) program from 185 percent of the federal poverty level to 200 percent. This change took effect on July 1, 2005, impacting births occurring in 2006 and later.

The Learning Communities Forum continued to focus on examining innovative and evidence-based approaches to preconception and prenatal care. The group continued to explore and discuss the challenges experienced by low-income women in accessing first trimester prenatal care across the state. The group provided three Web conferences and presentations to the medical, public health and health care financing communities as a bridge to increase communication on promising and evidence-based approaches with preconception and prenatal care. Conferences included Health Care Systems Quality Improvement Program developed by the Los Angeles (LA) Best Babies Network, The Baby and Me Tobacco Free smoking cessation program that targets pregnant and post-partum women, as well as an update on Perinatal Health Data provided by the MCH Demographer.

c. Plan for the Coming Year

The target for 2008 is 84.0 percent. Data to measure first trimester care will be derived from the revised birth certificate, in use since January 1, 2007. The old birth certificate, in use from 1989 through 2006, asked the mother what month she began prenatal care. The new birth certificate uses the date shown in the mother's medical record as the source for the information.

The new administration focus on women's health issues includes addressing unintended pregnancy. Women whose pregnancies are planned are more likely to begin care in the first trimester than women whose pregnancies are unintended. A renewed effort is underway to receive a Family Planning Medicaid Waiver. If approved, this will enable many more women to access effective contraception, thus reducing unintended pregnancy and the number of women that may delay obtaining prenatal care. While these changes may not impact 2008, they are likely to improve indicators in the years ahead.

The Learning Communities Forum will continue to focus on promising practice and evidence-based approaches to prenatal care highlighting national and local programs.

The MCH program is initiating an "Access to Care" state and local planning workgroup. The workgroup will examine existing enabling service strategies and to build support for systems building and community mobilization approaches to addressing access. The results generated

from this workgroup will provide the basis for a future MCH Action Guide regarding access that will be used as a framework for future access efforts at the state and local level.

D. State Performance Measures

State Performance Measure 1: *The proportion of children and adolescents attending public schools who have access to basic preventive and primary, physical and behavioral health services through school-based health centers*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	8.3	9.5	11.5	12	12.5
Annual Indicator	7.9	11.0	10.9	12.4	22.2
Numerator	59438	83668	83139	96907	176643
Denominator	751049	757668	766236	780708	794026
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	13	14	15	15	15

Notes - 2007
Data shown for reporting year 2007 are based on Fall 2006 school enrollment data. The numerator includes students in schools with school-linked or on-site school-based health centers.

Notes - 2006
Data shown for reporting year 2006 are based on Fall 2005 school enrollment data. The numerator includes students in schools with school-linked or on-site school-based health centers.

Notes - 2005
Data shown for reporting year 2005 are based on Fall 2004 school enrollment data. The numerator includes students in schools with school-linked or on-site school-based health centers.

a. Last Year's Accomplishments
The 2007 target was 12.5 percent. The target was met as the actual was 22.2 percent. The way data is counted changes, which accounts for the substantial increase from the previous year.

During the 2006-2007 school year there were forty school-based health centers and one mobile van serving eleven school sites. Health services were available to 86,525 children and adolescents in Colorado. Based upon total state enrollment of 794,026 public school students, 10.9 percent of all students in the state had access to preventive and primary physical including behavioral health services through school based health centers.
health centers.

School-based health centers are located in eleven of Colorado's 64 counties. They provided preventive and primary, physical and behavioral health services to 20,964 unduplicated users, generating 66,272 student visits. Of these visits, 10,934 or 16.5 percent were for mental health care, and 1,974 or 3 percent were for oral health care.

Six new school-based health centers opened during the 2006-2007 school year. They are located in La Plata, Montrose, Eagle, Jefferson and Prowers counties.

The Colorado Trust and Colorado Health Foundation co-commissioned an environmental scan of school health services that was published in March 2007. Findings from the scan will be used to

inform the School Health Improvement Initiative Task Force in making policy recommendations regarding the delivery of health services in Colorado public schools.

The Colorado Trust Foundation awarded the School-Based Health Center Program at the Colorado Department of Public Health and Environment $1 million over 2 years to assist communities in a planning process and to support start up on new centers. The funds will also support existing school-based health centers.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Helped to support the 40 school-based health centers and one mobile van serving eleven school sites provided services	X	X	X	
2. Published results from Environmental Scan of school health service delivery in Colorado public schools.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In addition to funding from The Colorado Trust, the Colorado General Assembly increased allocations for school-based health centers by approximately $500,000 resulting in a total just under $1 million for the fiscal year. Combined with the annual Colorado MCH block grant allocation of $275,000, the School-Based Health Center Program had approximately $1.7 million.

Three Requests for Applications (RFA's) were released March 31, 2008. One RFA was for communities wishing to go through a formal planning process. Four communities were given awards of up to $20,000 to complete the process. Another RFA was for communities who had completed the planning process and were seeking start up funding. Awards of up to $100,000 were given to two communities ready to start up their school-based health centers. The final RFA was for existing school-based health centers not currently receiving funding from the state School-Based Health Center Program. Two programs were awarded funding of up to $75,000 to support their centers. All new contractors are eligible to receive an additional two years of non-competitive funding pending contract compliance.

In addition, the eleven current contractors were invited to apply for an increased award. The award increase was determined by comprehensiveness of services and student utilization data for school year 2006-2007.

c. Plan for the Coming Year

A new measure will be devised that more accurately reflects access to school-based health care.

With an additional year of funding from The Colorado Trust and ongoing interest in expanding access to school-based health centers by the state legislature and local foundations, it is anticipated that the state program will continue to provide sustainable funding to school-based

health centers throughout the state. The program's ambitious goal is to increase the number of school-based health centers by 50 percent, from 40 to 60.

The Request for Application process will be replicated for the 2009-2010 school year with funding opportunities being offered for planning, start-up and continuation efforts. Contractors from the 2007-2008 cycle will enter their third year of non-competitive funding.

State Performance Measure 2: *Percent of Medicaid-eligible children who receive dental services as part of their comprehensive services*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	25	26	35	36	31
Annual Indicator	34.1	30.4	30.1	30.1	36.0
Numerator	89350	92140	117480	103011	121642
Denominator	262321	303090	390299	342229	338186
Is the Data Provisional or Final?				Provisional	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	32	37	37	38	38

Notes - 2007
Data shown for reporting year 2007 are for federal fiscal year 2007.

Notes - 2006
Data shown for reporting year 2006 are for federal fiscal year 2006. Data were revised (from a previous release) by CMS in May 2007.

Notes - 2005
Data shown for reporting year 2005 are federal fiscal year 2005 data that were revised by CMS in May 2007.

a. Last Year's Accomplishments
The 2007 target was 31.0 percent. The measure was exceeded with 36 percent achieved.

The percentage of EPSDT eligible children age 6 through 9 who received any dental services during the year exceeded 50 percent, which is nearing expectations for the insured population. While there is no single factor responsible for this increase, several initiatives described below have had a contributing effect

The Oral Health Unit continued to work with dental safety net providers, the Colorado Dental Association and the Colorado Dental Hygienists Association to improve dental access for Medicaid eligible children. The State Dental Loan Repayment Program continued to be highly competitive, with most participants seeing at least 40 underserved patients per month. This has led to 19,807 Medicaid-eligible children being seen by program participants in FY 2007, a 2,000 increase over the number served in FY 2006. The four year total of Medicaid eligible children seen by participants of this program is 56,641.

There were 398 billing providers with at least one paid claim, and 563 providers with at least one paid claim, this is half of the number of providers paid the previous year. This significant decrease is multifactorial, but reimbursement rates continue to be a major issue. A bill recently signed by the Governor increased dental Medicaid reimbursement rates from 47 percent to 52 percent of the American Dental Association mean for the Rocky Mountain Region. However, it is doubtful that this will result in any significant increase in providers as the rate is still low.

As a member of the Oral Health Awareness Colorado Coalition, the Unit provided testimony to the benefits taskforce for the Blue Ribbon Commission looking at health care reform for Colorado. The goal of this effort is to assure oral health benefits for adults in any benefit package considered. Insuring adults is becoming more important to ensuring the oral health of children. In the 2006 Child Health Survey, which is linked to the Colorado Behavioral Risk Factor Surveillance Survey, children of adults who had not seen a dentist in the previous year were four times more likely to have unmet dental needs.

Additionally, the Oral Health Unit participated in the Medical Home Advisory Task Force to assure oral health is integrated, per legislation, into the Medical Home concept.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Oral Health Unit continued to work with dental safety net providers, The Colorado Dental Association and the Colorado Dental Hygienists Association to improve access to Medicaid eligible children.	X	X	X	X
2. The State Dental Loan Repayment Program continued to be highly competitive	X	X	X	X
3. The Medicaid dental reimbursement rates increased from 47 percent to 52 percent.	X			X
4. Participated in the Medical Home Advisory Task Force to assure oral health is integrated, per legislation, into the Medical Home concept.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activities previously described will continue. The Oral Health Unit is currently providing technical assistance to the Cavity Free at Three (CF3) initiative, funded by a collaborative effort of four Colorado foundations. Experts from the University of California at San Francisco trained over 50 dental and medical providers to conduct oral health risk assessment and fluoride varnish placement. Colorado communities interested in implementing the CF3 model were selected to in an application process.

The Oral Health Unit worked closely with Medicaid to allow physicians, nurse practitioners, and physician assistants, who receive training in the CF3 protocol, to be reimbursed through Medicaid. Currently, 17 states allow medical providers to bill for preventive dental procedures. Due to the increased fiscal impact, it may take 12-15 months for the budget changes to occur for this to be realized in Colorado.

The Oral Health Unit is one of 18 states with a grant from the Bureau of Health Professions, Grants to States to Support Oral Health Workforce Activities. Colorado sued these funds to expand the number of dental loan repayment participants in addition to supporting the University of Colorado's "Colorado Smilemakers" mobile dental van. In the van's first year of operation, a total of 155 children were seen in three rural counties.

c. Plan for the Coming Year
With increased awareness of the importance of oral health to overall systemic health, there is increased interest in reducing barriers and improving access to dental services. The Oral Health Awareness Colorado coalition will be releasing a "Midcourse Review" of the state oral health plan, in which success stories will highlight the efforts made to improve the oral health of Medicaid children and all at-risk populations in Colorado. In addition, Colorado has applied for second five-year Centers for Disease Control's Oral Health cooperative agreement, which will assure the infrastructure and capacity at the state level to address these issues.

State Performance Measure 3: *The percentage of women with inadequate weight gain during pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	23	23	22.5	22.3	22
Annual Indicator	24.5	22.9	24.5	18.7	27.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	20.7	18	18	18	18

Notes - 2007
Data shown for 2007 are from the 2006 Pregnancy Risk Assessment Monitoring System (PRAMS).

Notes - 2006
Data shown for 2006 are from the 2005 Pregnancy Risk Assessment Monitoring System (PRAMS).

Notes - 2005
Data shown for reporting year 2005 are 2004 Colorado PRAMS survey data.

a. Last Year's Accomplishments
The 2007 target was for no more than 22.0 percent of pregnant women to gain an inadequate amount of weight during pregnancy. PRAMS data for reporting year 2007 showed a rate of 27.5 percent, well above the target goal. Data from the previous year indicated a rate of 18.7 percent, easily meeting the previous year's target of 22.3 percent. The changes shown for the three most recent reporting years (2005-2007) show a statistically significant decline and increase in the period, but it is unclear why reporting year 2006 data showed such a low percentage.

With the release of Tipping the Scales: Weighing in on Solutions to the Low Birth Weight Problem in Colorado in 2000, a long-term effort to reduce the incidence of inadequate weight gain during pregnancy was initiated. Historically one in four women in Colorado do not gain an adequate amount of weight during pregnancy, which has a significant impact on the low birthweight rate. The report states that Colorado's low birthweight rate (among singleton births) could be reduced by nearly a full percentage point if all women gained the recommended amount of weight during pregnancy.

The Women's Health Section initiated a social marketing campaign to address the issue of inadequate weight gain. A campaign was developed called "A Healthy Baby is Worth the Weight." The social marketing plan includes collaboration with key stakeholders, provider trainings, and a

consumer campaign. A website, www.healthy-baby.org was developed to augment the social marketing approach. The site allows consumers to calculate their body mass index (BMI) values and provides recommendations on appropriate weight gain for each pre-pregnancy BMI category. A printable weight gain grid, patient education brochures, combination BMI/ gestational wheel and an "Ask the Dietitian" section are included. Prenatal care providers can access reports and research publications, practice strategies, community resources, and focus group findings.

From October to December, Weld, El Paso and Mesa counties launched consumer and provider campaigns to encourage adequate weight gain during pregnancy. MCH funds were used for provider trainings and systems change implementation in Denver, El Paso and Mesa counties. The "Campaña Healthy Baby", targeting Latino families, was launched from November to December. This media campaign included television and radio advertisements, posters placement in bus shelters, laundromats, and health care clinics and brochure distribution. Placement of advertisements was based on the location of the Latina population in the Denver area. Several on-air interviews were conducted with a Latina spokeswoman for both television and radio. Vignettes promoting the message and the website were recorded and aired.

The number of hits to the healthy-baby.org website increased substantially during the campaign. October website hits increased 36 percent over September's hits. For the first time, in November the Spanish materials were listed in the top 10 hits to the website.

Components of the Healthy Baby campaign, such as provider trainings, key informant interviews and consumer outreach, were incorporated into community-level MCH plans. Training and technical assistance were provided to local health departments.

Presentation about the campaign continued to be offered to professional groups.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Weld, El Paso and Mesa counties launched consumer and provider campaigns to encourage adequate weight gain during pregnancy.			X	
2. Supported provider trainings and systems change implementation in Denver, El Paso and Mesa counties.			X	X
3. The "Campaña Healthy Baby", targeting Latina families, was launched.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

After the development of the Latina Campaign, entitled "Campaña Healthy Baby", the decision was made to change the title of the social marketing campaign, "A Healthy Baby is Worth the Weight", to the "Healthy Baby Campaign." This decision was made to allow for expansion of campaign efforts to more fully incorporate smoking cessation outreach and appropriate weight gain emphasis (not just inadequate weight gain).

A MCH Healthy Baby Action Guide at http://www.cdphe.state.co.us/ps/mch/actionguides.html

was developed that incorporates strategies to address both appropriate weight gain during pregnancy and prenatal smoking cessation. Currently ten of the 15 local health departments in Colorado have incorporated the Healthy Baby campaign as part of their MCH operational plans. Some of the agencies have elected to focus on consumer outreach and placement of billboards, busboards and radio or television advertisements. Other local health agencies conducted provider trainings and provided toolkits for use in clinical provider setting.

Plans are underway to redesign the website to reflect the broader emphasis of the campaign and include preconception care components, gestational diabetes guidelines, and postpartum depression resources. With the integration of the prenatal smoking cessation components, prenatal smoking cessation messaging and outreach were added to complement the appropriate weight gain messaging.

c. Plan for the Coming Year

The target for reporting year 2009 is 18.0 percent. This level was nearly reached in reporting year 2006, and the goal is retained for the forseeable future. An analysis of the reasons behind the decline and increase will be undertaken, and the results should provide direction for next steps.

During the upcoming year MCH operational plans will transition from one-year plans to three-year plans. Counties that wish to incorporate prenatal smoking cessation and appropriate weight gain will use the MCH Healthy Baby Action Guide to develop local strategies. Consumer and provider outreach will continue via local health agency and state health agency efforts. Professional presentations that promote the Healthy Baby campaign will continue. Consultation and technical assistance will be provided to agencies choosing to use Healthy Baby strategies in their MCH plans. A new website will be operational that will promote emerging preconception care guidelines and use an expanded life course perspective.

State Performance Measure 4: *The rate of birth (per 1,000) for Latina teenagers age 15-17*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				73.7	71.9
Annual Indicator	79.9	73.7	72.6	72.8	69.6
Numerator	1380	1360	1451	1413	1412
Denominator	17268	18450	19983	19411	20297
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	70	68.2	66.3	65	64

Notes - 2007

State Performance Measure #4, the rate of birth for Latina teenagers age 15-17, has been dropped from the state's list of performance measures, effective 10/1/2007.

The data shown for reporting year 2007 are 2006 calendar year data.

Notes - 2006

Data shown for reporting year 2006 are 2005 calendar year data.

Notes - 2005

Data shown for reporting year 2005 are 2004 calendar year data.

a. Last Year's Accomplishments

This measure is discontinued.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This State Performance Measure was discontinued.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
This measure is discontinued.

c. Plan for the Coming Year
This measure is discontinued.

State Performance Measure 5: *The motor vehicle death rate for teens 15-19 years old.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				28	18
Annual Indicator	28.6	29.0	31.2	18.6	19.0
Numerator	96	99	107	65	67
Denominator	335762	341500	342486	348573	352852
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	17	16	15	14	13

Notes - 2007
Data shown for reporting year 2007 are 2006 calendar year data.

Notes - 2006
Data shown for reporting year 2006 are 2005 calendar year data.

Notes - 2005
Data shown for reporting year 2005 are 2004 calendar year data.

a. Last Year's Accomplishments
The 2007 target was 18.0 deaths per 100,000 teens. The measure was not met with 19.0 per 100,000 teens achieved.

The Child, Adolescent, and School Health (CASH) and Injury, Suicide and Violence Prevention (ISVP) Units continued convening the Teen Motor Vehicle Leadership Alliance. The Alliance is an interagency statewide partnership to reduce teen motor vehicle crashes and improve teen motor vehicle safety.

The Alliance assessed assigned member organization responsibility for objectives associated with the Teen Motor Vehicle Leadership Alliance Work Plan. Four workgroups were created to carry out workplan activities: Keeping Us on Track (coordination and oversight), Social Marketing/Media, Local Communities (planning and development), and Legislative (support primary seatbelt legislation, if proposed).

The Social Marketing/Media Workgroup developed a widespread, youth/parent-driven, culturally responsive social marketing campaign to educate and motivate law enforcement personnel, parents and youth to follow Colorado's Graduated Drivers Licensing (GDL) law. The launch of the social marketing campaign included a press conference with the Governor and First Lady Ritter, who discussed the importance of teen motor vehicle safety.

Quarterly teen driving safety toolkits that included public service announcements, sample newsletter articles, website banners, fact sheets, posters, and print ads were created and distributed to schools across Colorado. Additionally, the Alliance developed and distributed 100,000 GDL brochures in English and Spanish to teens and their parents through the motor vehicle departments, public health agencies, schools and other local partners. For more information go to http://www.coloradoteendriver.org.

The Alliance supported seatbelt legislation during the legislative session, and the bill failed to pass by one vote.

The Alliance provided technical assistance and consultation to state and local community organizations interested in or currently addressing teen motor vehicle safety. The Alliance provided additional incentive funding to communities that demonstrated a need and had comprehensive action plans based upon best practices that highlighted interagency approaches.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintained the Teen Motor Vehicle Leadership Alliance.				X
2. Implemented a social marketing campaign to educate and motivate law enforcement, parents, and youth to follow Colorado's GDL Law.			X	
3. The Alliance assigned member organization responsibility for carrying out workplan objectives.			X	
4. The Alliance provided technical assistance and consultation to statewide and local community organizations interested in or currently addressing teen motor vehicle. safety.			X	X
5. Distributed materials and resources.		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Teen Motor Vehicle Leadership Alliance met monthly to coordinate the implementation of their workplan. The Alliance distributed 65,000 brochures in English and Spanish to teens and their parents. New teen driving toolkits were created and posted on the Colorado Teen Driver website and distributed quarterly to schools.

The Alliance continued to support law enforcement, schools, and other programs to create and enforce safety belt policies. It developed and disseminated a plan for a school seatbelt policy drafted with adult and youth input.

The Colorado Department of Transportation (CDOT), DriveSmart Colorado Springs and the Colorado State Patrol took the lead in developing a 10-minute video that can be used as a training tool for law enforcement. The video addressed the nuances of the GDL law and encourages officers to enforce it. This "Roll Call" video is designed for use at staff meeting. It has been distributed across the State.

The Alliance's Keeping Us on Track Workgroup began development of teen motor vehicle data measures.

The Injury, Suicide and Violence Prevention Unit (ISVP) created a best practice document it is at http://www.colorado.gov/bestpractices. The Teen Motor Vehicle Hospitalizations Fact Sheet was updated. http://www.cdphe.state.co.us/pp/injuryprevention. A Teen Motor Vehicle Safety Learning Community was convened. The MCH Action Guide for this area is at http://www.cdphe.state.co.us/ps/mch/actionguides.html.

c. Plan for the Coming Year
The 2008 target set for this performance measure is 16.0 deaths per 100,000 teens.

The state health department will continue to convene the Teen Motor Vehicle Leadership Alliance.

The Alliance will continue to work with the Department of Transportation, the Division of Motor Vehicles, insurance companies, and schools to support parents by updating and distributing the social marketing campaign materials and providing guidance regarding enforcement of the GDL law.

The Alliance will also provide information in response to primary seatbelt legislation if it is proposed in the 2009 legislative session.

The Alliance will evaluate some of the teen driving programs used around the State, including the "Roll Call" Video described above. Additionally, evaluation tools for local communities and programs that are implementing teen motor vehicle safety strategies will be developed and promoted.

To promote evidence-based practices and encourage coordination of teen motor vehicle safety efforts around the state, ISVP will work with the Alliance to compile and disseminate a teen motor vehicle resource directory for local communities that contains links to evidence based programs and other resources. A list serv will be developed to notify communities about relevant press releases and grant opportunities. The Alliance is considering hosting the first Colorado Teen Motor Vehicle Annual Meeting for state and local partners addressing teen motor vehicle safety issues.

State Performance Measure 6: *Percent of mothers smoking during the 3 months before pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				15.9	15.3

Annual Indicator	20.1	18.7	21.3	20.2	20.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	14.8	19.5	19	18.5	18

Notes - 2007
Data shown for reporting year 2007 are 2006 Pregnancy Risk Assessment Monitoring System (PRAMS) data.

Notes - 2006
Data shown for reporting year 2006 are 2005 Pregnancy Risk Assessment Monitoring System (PRAMS) data.

Notes - 2005
Data shown for reporting year 2005 are 2004 Colorado PRAMS survey data.

a. Last Year's Accomplishments
The 2007 target was 15.3 percent. The target was not met with 20.3 percent achieved.

A study in 2000 by CDPHE determined that one out of every eight low birthweight births could be attributed to smoking and that the state's low birth weight rate could be reduced by 12.5 percent if no women smoked during pregnancy.

Four local MCH contractors implemented a consumer-based strategy to address both prenatal weight gain and smoking cessation among women of reproductive age. Staff from the local public health departments worked with local tobacco prevention education partners to conduct key informant interviews and developed community action plans to expand residents' knowledge of and access to the Colorado QuitLine. The Colorado QuitLine was launched in 2001 and is promoted statewide. According to State Tobacco Education and Prevention Partnership (STEPP) program data, the overall 6-month quit rates for those who used the QuitLine in 2007 was 29 percent versus the three to five percent quit rate for those who try to quit on their own. QuitLine staff follows a protocol for pregnant smokers, and utilized tailored self-help materials adapted from the Smoke-Free Families Initiative.

The STEPP media and marketing campaigns continued. The statewide, youth focused "Own Your C" (C refers to choices) Web campaign reached over 421,000 Colorado youth as measured by hits to the award-winning Web site (www.ownyourc.com). There were 6,000 youth members involved with the campaign and nearly 100 new members were added each month. The campaign strived to reduce the number of girls and young women who initiate tobacco use.

Women who used tobacco were encouraged to access the Colorado QuitLine for professional smoking cessation assistance.

The WIC program continued to require assessment of the smoking status of all pregnant, postpartum, and breastfeeding women. The program referred women who smoke to the Colorado QuitLine for cessation assistance. STEPP staff trained WIC providers in the 5 A's counseling method to ensure that clients who smoked received cessation assistance and learned how to reduce exposure to secondhand smoke.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Four local MCH contractors implemented a consumer-based strategy to address both prenatal weight gain and smoking cessation among women of reproductive age.	X	X	X	
2. The STEPP media and marketing campaigns continued.			X	
3. The WIC program continued to require assessment of the smoking status of all pregnant, postpartum, and breastfeeding women.	X		X	X
4. STEPP staff trained WIC providers in the 5 A's counseling.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Prenatal smoking cessation strategies were incorporated along with appropriate weight gain strategies into a MCH Healthy Baby Action Guide. Ten local health agencies addressed Healthy Baby strategies in their MCH implementation plans.

An external advisory group has been formed with statewide partners to strengthen prenatal smoking cessation messages. Colorado Clinical Guidelines Collaborative (CCGC), State Tobacco Education and Prevention Partnership (STEPP) and Women's Health are leading the organizational efforts associated with the panel. The panel will formulate a consensus statement and messaging specific to prenatal smoking cessation.

Work is proceeding to design a division-wide plan to address prenatal smoking cessation among the following programs: WIC, STEPP, Prenatal Plus, and the Nurse Family Partnership.

The STEPP grant process continued to fund outreach to women of reproductive age through the Colorado QuitLine and provides services to include free nicotine replacement therapy with a doctor's prescription. STEPP continued statewide media and website campaigns targeting adolescents (12-18 year olds) and young adults (19-25 year olds). The STEPP "Own Your C" media campaign, QuitLine resources and indoor smoking ban in Colorado continued to be helpful deterrents to initiating smoking for women of childbearing age.

c. Plan for the Coming Year

Once the Colorado statewide consensus statement and Prevention Service's Division project team recommendations are complete, they will be integrated into relevant division and state plans to more fully address the issue of prenatal smoking cessation. Community-level MCH plans will continue to incorporate prenatal smoking cessation messages with appropriate weight gain recommendations to help reduce Colorado's low birthweight rate. The newly developed Healthy Baby Action Guide and other Healthy Baby resources will continue to be available.

It is anticipated STEPP's media campaigns will continue and may expand.

The Family Planning, Nurse Family Partnership and WIC programs will continue prenatal smoking cessation efforts.

This state performance measure is very similiar to National Performance Measure 15 and the activities are essentially identical. Beginning next year this measure will be retired. Activities associated with prenatal smoking cessation, discouraging women and youth from starting to use tobacco and assistance with smoking cessation will be reported in NPM 15.

State Performance Measure 7: *The proportion of all children 2-14 whose BMI is at or above 85% of normal weight for height.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				28.6	28.6
Annual Indicator		28.6	28.8	27.5	25.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	27	25	25	24	24

Notes - 2007
Data shown for reporting year 2007 are calendar 2007Colorado Child Health Survey data for children age 2-14.

Notes - 2006
Data shown for reporting year 2006 are calendar 2006 Colorado Child Health Survey data.

Notes - 2005
Data shown for reporting year 2005 are calendar 2005 Colorado Child Health Survey data.

a. Last Year's Accomplishments
The 2007 target was 28.6 percent. The target was exceeded with 25.8 percent achieved.

The Early Childhood and the School Site Taskforces of the Colorado Physical Activity and Nutrition (COPAN) Program participated in collaborative activities in this area. Participants in these taskforces include representatives from the The Children, Adolescent and School Health Unit, Child and Adult Care Food Program, WIC, USDA, Healthy Child Care Colorado, Colorado Physical Activity and Nutrition Program, Head Start, Colorado State University, Colorado Department of Education, local public health agencies, Action for Healthy Kids (Western Dairy Council), YMCA, Healthier Generation, University of Colorado at Denver Health Sciences Center, Rocky Mountain Center for Health Promotion and Education, as well as many other interested partners. Each taskforce developed and marketed tool kits based on physical activity and nutrition best practices. The resource kits were developed for community-based programs interested in implementing obesity prevention strategies, http://www.cdphe.state.co.us./pp/COPAN/resourcekits/resourcekits.html.

The Children, Adolescent and School Health (CASH) Unit took an active role in promoting the Colorado Connections for Healthy Schools (Colorado's CDC-funded Coordinated School Health Program). The project was co-directed by staff from the CASH unit and the Colorado Department of Education (CDE). The goal was to collaboratively engage health departments, schools and other community partners in developing and implementing effective policies and programs to promote a healthy school environment school age children and youth, based upon promising practices in physical activity and nutrition.

The CASH Unit co-facilitated a workgroup to address the coordination of school surveys. The goal was to eliminate duplicative requests from programs, funders and researchers that asked schools to participate in numerous (and possibly similar surveys) and to provide the State and schools with representative data regarding student risk, health and protective factors. The combined surveys were the Youth risk Behavior Survey (YRBS), the Youth Tobacco Survey and the Colorado Youth Survey (substance abuse survey that includes items related to resilience and

youth assets). The workgroup's efforts resulted in the coordination of all three surveys into identified modules and a consistent schedule for survey administration was set. All surveys will fall under one title, Colorado Healthy Kids Survey. Schools will be randomly assigned to complete one or more modules each year. The Colorado Healthy Kids Survey for 2006-2007 included the Youth Tobacco module. The Colorado Health Kids survey for 2007-2008 includes the YRBS and the Colorado Youth modules.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participated in coalition activities.				X
2. Carried out the Colorado Heights and Weights program with the Oral Health Unit.	X		X	X
3. Engaged in collaborative efforts to encourage schools to implement Coordinated School Health Activities.			X	X
4. Participated in collaborative activities associated with the Colorado Child Health Parent Survey and the Healthy Kids Student Survey.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Colorado Heights and Weights Project continued. It was a joint venture with the Oral Health Unit. Children from the 49 selected schools could also participate in dental screening program.

Maternal and Child Health resources were used to fund collaborative efforts to develop school health teams in 30 schools throughout Colorado. Other partners included Colorado Connections for Healthy Schools, The Rocky Mountain Center for Health Promotion, the Tobacco Prevention Program and the Colorado Physical Activity and Nutrition Program. Collaborative funding also supported the development of a comprehensive guide for schools and communities for use in developing and implementing health teams focused on improving the school health environment. the Colorado Roadmap to Healthy Schools can be viewed and downloaded at http://www.rmc.org/CSH/roadmap.html .

Colorado was one of 22 states awarded a new five-year grant from the CDC's Division of Adolescent and School Health to continue Colorado Connections for Health Schools, the Colorado Coordinated School Health Program. The funds will be used to continue building a statewide infrastructure that supports a coordinated health model in all Colorado schools.

c. Plan for the Coming Year

Plans include ongoing support of current collaborative efforts between public health agencies and schools directed at developing school and community-based policies and activities to improve healthy lifestyles for children and youth. The Colorado Connections for Healthy Schools (Colorado's Coordinated School Health Program) and CASH staff are engaging interested stakeholders, foundations, public health agencies, community organizations, academic partners and schools in multiple efforts to stem the increase in childhood obesity. The goals involve developing the communities and schools to be resources for children, youth and their families

needing health promotion and prevention information and opportunities to practice healthy lifestyle behaviors. Examples of the community partners that are engaging in these collaborative efforts include a Live Well Community Organization funded through a large Kaiser Pemanente grant; the Denver Metro Health and Wellness Task force, facilitated by the Lieutenant Governor; state health department programs; local public health agencies, and Colorado Action for Healthy Kids.

Researchers from the Rocky Mountain Prevention Center, Colorado State University (CSU) and University of Northern Colorado (UNC) are proposing pilot projects. Foundations are considering funding initiatives that include best practice strategies and activities to promote healthy eating and physical activity for families, children and youth. Academic partners such as CSU & UNC are working collaboratively to submit a grant application that will pilot an after school program that educates both students and families about healthy nutrition and provides opportunities for physical activities. The Rocky Mountain Prevention Center has submitted a grant application to provide electronic data collection equipment for schools to collect and analyze heights and weight as well as other student health data.

The CASH Unit will continue to fund the development of school health teams and local public health agencies are being encouraged to adopt best practice strategies for addressing childhood overweight and obesity as part of their MCH planning.

The Colorado Heights and Weights Project will continue. This data will help determine baseline information regarding the weight status of school-age children in Colorado.

The Child, Adolescent, and School Health Unit will produce an online resource for child growth and development. This resource will include a review of growth and development concepts from birth to eighteen years and include anticipatory guidance resources. Nutrition will be one of the major concepts addressed throughout the course. Course development will be a collaborative effort between state health department programs (COPAN, CASH and WIC), early childhood experts, academic partners and child development professionals.

State Performance Measure 8: *Percent of children who have difficulty with emotions, concentration, or behavior.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				28	28
Annual Indicator		28.5	29.2	25.3	28.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	27	26	26	25	25

Notes - 2007
Data shown for reporting year 2007 are calendar year 2007 Colorado Child Health survey data for children age 1-14.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2006 Colorado Child Health survey data.

Notes - 2005
Data shown for reporting year 2005 are calendar year 2005 Colorado Child Health survey data.

a. Last Year's Accomplishments
The 2007 target was 28 percent. The target was essentially met with 28.2 percent achieved.

With the help of over 300 stakeholders across Colorado, including five different state department leaders and First Lady Ritter, the Colorado LINKS for Mental Health Initiative developed and finalized Colorado's Behavioral Health Action Plan for Children, Youth, and Their Families. The plan is focused on the following three priorities: integrating state-level behavioral health efforts; building partnerships with families and youth; and creating innovative mechanisms for budgeting, funding and financing.

Statutory entities, including the Colorado Prevention Leadership Council, the System of Care Collaborative and the Mental Health Planning and Advisory Council, met jointly to develop formal Memoranda of Agreement (MOA) around the three LINKS' priorities. The MOA will facilitate efforts to better coordinate, decrease duplicative efforts and streamline future activities.

Established interagency groups carried out the activities of Colorado's Behavioral Health Action Plan for Children, Youth, and Their Families.

A social network survey was conducted and results were presented to the Grant Implementation Group (LINKS executive committee) and other interested partners. The survey looked at the relationships between fifteen key divisions, units, and offices within five state departments. Using an approach called social network analysis, the Colorado LINKS for Mental Health evaluator identified changes in collaboration and partnership accomplished through participation in LINKS. (attachment)

Results included:
Leadership in the Colorado mental health system was gradually centering on three state departments: the Department of Human Services, Division of Mental Health and Division of Child Welfare; the Colorado Department of Public Health and Environment's Prevention Leadership Council; and the Department of Health Care Policy and Finance's, Medicaid Program.

The networks have changed significantly in the eighteen months between the three rounds of the survey with the addition of new partners and better coordination of activities. Partnership activities have increased by 32 percent, particularly between state departments.

State departments are increasingly more likely to engage in partnership activities with other state departments.

Colorado Department of Human Services (CDHS) and the Colorado Department of Public Health and Environment (CDPHE) serve as important link with other state agencies. The Departments of Education, Public Safety, and Health Care Policy and Financing are not connected directly to each other, either through perceptions of important partnerships or actual partnership activities; rather they are indirectly connected through CDHS and CDPHE.

Barriers to collaboration include limits upon staff time and resources. However, opportunities exist for improved collaboration among the various partners.

Survey participants identified that the LINKS Initiative provided opportunities for collaboration regarding areas of common interested among different agencies.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Developed and finalized action plan.				X
2. Statutory entity collaboration completed				X
3. Identified interagency groups to carry out action plan activities.				X
4. Social network survey/evaluation completed.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Colorado LINKS for Mental Health began implementing Colorado's Behavioral Health Action Plan for Children, Youth, and Their Families through a two-year grant from the Colorado Health Foundation. A list of thirteen benchmarks are being addressed over two years. Three leadership teams were developed based on the three LINKS' priority areas. They are: integrating state-level behavioral health efforts; building partnerships with families and youth; and creating innovative mechanisms for budgeting, funding and financing.

As part of the Integration of State-Level Behavioral Health Efforts Group six state agency executive directors and Governor Ritter signed a commitment statement. The statement outlines agreements that should lead to systems enhancement and better use of resources. The workgroup also identified regulation changes that, if enacted, would improve integration of behavioral health efforts.

The Partnering with Families and Youth Priority Workgroup developed training information and provided technical assistance to interagency councils, boards and commissions on how to build effective partnerships with families and youth was provided. In addition, families and youth across Colorado were trained on how to be effective participants on councils, boards and commissions.

The Streamlining Budgeting, Funding and Financing Priority Workgroup identified barriers to these efforts. In August, the group completed a cost-benefit analysis regarding these types of functions

c. Plan for the Coming Year
The Colorado LINKS for Mental Health will continue to focus on the above-mentioned priorities in year two of the implementation grant for Colorado's Behavioral Health Action Plan for Children, Youth, and Their Families.

As part of the Integration of State-Level Behavioral Health Efforts Workgroup, agreements and formal memoranda of agreement will be developed, signed and monitored. In addition, descriptive language will be developed for insertion into proposals or applications. These statements will better describe vague terms such as "involving youth in activities".

A virtual clearinghouse for local communities will be developed that includes examples of current activities; lessons learned; step-by-step guides from state and national efforts; and tools addressing cultural responsiveness, assessment and evaluation.

For the Partnering with Families and Youth Priority Workgroup, families and youth will be offered training on how to be effective when serving on a board or council. Training and technical assistance will be offered to interagency councils, boards and commissions about how to effectively use the assistance of families and youth. In addition, an online clearinghouse that

contains names of trained interagency groups will be available for trained families and youth seeking an opportunity to participate in a board or council.

For the Streamlining Budgeting, Funding and Financing Priority Workgroup recommendations for change based on the identified barriers and the cost/benefit analysis will be shared with state agencies and interagency groups.

State Performance Measure 9: *Percent of center-based child care programs using a child care nurse consultant.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				90	92
Annual Indicator				88.6	90.0
Numerator				1528	1709
Denominator				1724	1898
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	94	96	98	98	98

Notes - 2007
Data shown for reporting year 2007 are calendar year 2007 data.

Notes - 2006
Data shown for reporting year 2006 are data from the Spring 2006 Qualistar Survey.

Notes - 2005
No data are available for reporting year 2005.

a. Last Year's Accomplishments
The 2007 target was 92 percent. The target was not met as the actual was 90 percent.

Healthy Child Care Colorado (HCCC) is a MCH-supported program that provides consultation, technical assistance and training to enhance the health and safety needs of young children. The HCCC Director, who is housed at the Qualistar Early Learning program located in Denver, provided four trainings designed to meet the needs of health care professionals who provide child health consultation around the state. Additionally, there is an online training program for child care health consultants, http://www.co.train.org.

Qualistar Early Learning is a nonprofit organization that coordinates the statewide child care resource and referral network. The group conductes a statewide bi-annual survey of child care providers through the Child Care Resource and Referral Network. To obtain ongoing annual data for this performance measure, the MCH Program paid to include three specific questions in the Qualistar survey.

Originally designed by the Boulder County Public Health (BCPH), the Child Health Liaison course improves a child care program's expertise in health and safety. Annually, staff from BCPH trained one child care provider each from 15 different centers as a child health liaison. Working with their child care center's nurse consultant, each child health liaison participated in assessing and improving the overall health and safety of the child care environment, children, and staff. The program was evaluated over the past seven years and data obtained by an independent evaluation shows that the quality of child care in the participating centers improved after child care providers completed the course.

State staff worked with BCPH to develop an online Child Health Liaison Course. The course was designed for anyone providing out-of-home care, including providers in family child care homes, Head Start Programs, child care centers and preschools. The online course includes ten modules. Completion of all ten modules meets the annual hours required by the state licensing agency for child care providers.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued contracting with Qualistar Early Learning to coordinate the Healthy Child Care Colorado Program			X	X
2. Supported on-line training of child care staff.				X
3. Develop on-line Child Health Liaison Course.				X
4. Hosted three learning community about the online course.				X
5. Provide training for child care consultants.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Healthy Child Care Colorado offeres an online introduction to child care health consultation, which is available at http://www.co.train.org. Approximately 160 people have registered for the training and 92 have completed the online course since it was posted in early summer 2005.

The HCCC program hosted three Health and Safety in Child Care Learning Communities, one in Grand Junction in western Colorado. The learning communities presented strategies and information to promote the implementation of the Child Health Liaison Program. Technical assistance site visits were made to two local public health agencies. Three technical assistance conference calls were hosted, linking four local public health agencies.

Last year 50 percent of child care providers in the El Paso County (a community with low utilization rates) used a child care nurse consultant, this year it is 64 percent. This increase is attributed to the sharing of information with El Paso County Public Health Department and their increased focus on health and safety in child care.

In Colorado, state regulations require that child care providers use the services of a child care health consultant. The survey results indicated that 90 percent of the responding centers were actively using a child care nurse consultant and of these sites 95 percent stated that they were satisfied with the consultation services they received.

c. Plan for the Coming Year

The 2007 Qualistar data regarding the utilization of child care nurse consultants will be sent to local and state partners in order to assist community-based efforts to improve this initiative. The data will continue to be included in the MCH County Datasets.

Communities that reported lower utilization rates of child care nurse consultants will receive technical assistance to improve rates through a collaborative effort to identify targeted strategies

including training for state child care licensing staff and local early childhood councils.

The program will continue to promote statewide activities including training and support for child care nurse consultants and expansion of the Child Health Liaison program.

With the expansion of the CHL program to the Pueblo, Colorado Springs and Frisco communities, the state team will collect information about the development and lessons learned during the start of and implementation of the project. This information will be compiled into a resource document and shared with communities interested developing their own program.

State Performance Measure 10: *The proportion of high school students reporting binge drinking in the past month.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				30	29
Annual Indicator			30.6	30.6	30.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	29	28	28	27	27

Notes - 2007
Data shown are Fall 2005 Colorado Youth Risk Behavior Survey results first reported in 2005. No newer data are available. The YRBS Survey was conducted in the Fall of 2007, but results were not available at the time these data were submitted.

Notes - 2006
Data shown are Fall 2005 Colorado Youth Risk Behavior Survey results reported in 2005. No data are available for 2006. Survey conducted every other year.

Notes - 2005
Data shown are Fall 2005 Colorado Youth Risk Behavior Survey results.

a. Last Year's Accomplishments
The 2007 target was 29.0 percent. The target was not met as the actual remains 30.6 percent.

The Colorado Prevention Partners, an initiative of the Colorado Prevention Leadership Council, is a statewide local coalition-building effort. The partners include coalitions and organizations from the Ute Mountain Ute Tribe and these counties: Alamosa, Costilla, Denver, Garfield, Gunnison, Kit Carson, Las Animas, Mesa, Prowers, Pueblo, Rio Grande, and Weld. Many of the coalitions that participate in the Colorado Prevention Partners address the issue of underage drinking.

The Colorado Prevention Partners Project began implementation of recently developed strategic plans. The partners also began implementing evidence-based strategies to address problems and goals identified in the plan. The state health department's Children, Adolescent and School Health (CASH) Unit continued to provide technical assistance and consultation, that included helping communities monitor and evaluate their plans for effectiveness.

The Colorado Prevention Partners Project, Underage Drinking Prevention and Reduction workgroup shared their expertise with local Colorado communities. The group assisted local

prevention planning boards with infrastructure development issues.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuation of the Colorado Prevention Partners to influence teen binge drinking.				X
2. Provided technical assistance to Colorado community coalitions addressing underage drinking prevention.			X	X
3. Began implementation of the strategic plan.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Colorado Prevention Partners leadership focused on sustainability of local coalitions and shared lessons learned in addressing underage alcohol use.

Two new coalitions were started in Cortez and Delores and Montezuma Counties. Funding for the coalitions came from Juvenile Delinquency Prevention.

The Underage Drinking Prevention and Reduction Workgroup was led by the Colorado Department of Human Services, Alcohol and Drug Abuse Division. The workgroup gathered information about underage alcohol possession, consumption and enforcement statutes in Colorado. They also identified additional resources allocated to address underage drinking and provided technical assistance to communities.

The workgroup provided technical assistance to support community reviews of evidence-based programs, policy options and practices. They also supported the development of a DUI track curriculum of education and treatment specifically for youth ages 20 and under. The workgroup also assisted in the administration of the Healthy Kids Colorado Survey

The Underage Drinking Prevention and Reduction Workgroup began development of a set of underage drinking data measures. They also supported the expansion, centralization, and maintenance of a social indicator datasets on underage drinking, contributing factors and consequences housed on the state health department's ASPIRE database.

c. Plan for the Coming Year

The Underage Drinking Prevention and Reduction Workgroup will develop and implement statewide, culturally responsive social marketing campaign that educate and support law enforcement personnel (officers, judges and attorneys) in enforcing the underage possession and consumption of alcohol laws. The workgroup will also provide judges and district attorneys with a menu of successful evidence-based program options that address underage possession and consumption violations, in addition to mandated consequences.

The workgroup will support law enforcement in carrying out Colorado's statutes regarding adults furnishing alcoholic beverages to youth under the age of 21 through community-based education and information dissemination. The workgroup will encourage law enforcement officers, district

attorneys and judges to pursue the source of the alcohol when minors are cited for possession, consumption or related offenses.

Other workgroup priorities include education efforts for youth and parents about Colorado statutes affecting young driver's driving privileges; supporting law or liquor enforcement personnel in conducting alcohol compliance checks; educating retail outlet staff on the importance of responsible alcohol sales practices; and providing support and technical assistance to communities about the evidence-based programs, policies and practices identified by community-based Underage Drinking Prevention Coalitions.

E. Health Status Indicators

Health Status Indicator Measure # 01A
The percent of live births weighing less than 2,500 grams

/2007/
This indicator is the same as Colorado's state outcome measure. The low birth weight rate shows an increase since reporting year 2001, with a possible start downward in the desired direction beginning in reporting year 2005. It is worthwhile to note also that the number of births reached a peak in reporting year 2004, and dropped by over 800 between 2004 and 2005. /2007/

/2008/
The low birth weight rate for reporting year 2006 was 9.3 percent, the highest low birth weight rate since 1973. The downturn in the rate from 9.1 percent to 9.0 percent reported above was not continued; in fact the rate jumped by 0.3 percentage points, a large increase. //2008//

/2009/
The low birth weight rate for reporting year 2007 was 9.0 percent, a decline from the previous year when it was 9.3 percent. The LBW rate for four out of the last five years was 9.0 percent. //2009//

Health Status Indicator Measure # 01B
The percent of live singleton births weighing less than 2500 grams

/2007/
The singleton low birth weight rate climbed steadily upward over the time period shown in the table, from 6.8 percent in reporting year 2001 to 7.2 percent in reporting year 2005. Unlike the low birth weight rate for all infants, which declined in 2005, the singleton rate continued to increase. 2007/

/2008/
The singleton low birth weight rate rose again, reaching 7.3 percent in reporting year 2006. While there is no long-term data available on this rate, it is likely that it is the highest in over 30 years. //2008//

/2009/
The singleton low birth weight rate declined from 7.3 percent to 7.2 percent in reporting year 2007. //2009//

Health Status Indicator Measure # 02 A
The percent of live births weighing less than 1,500 grams

/2007/
The state very low birth weight rate has remained at 1.3 percent for the past five years shown in the table. This rate is considerably above the Healthy People 2010 0.9 percent target. /2007/

/2008/
The state very low birth weight rate remained at 1.3 percent, showing no change from recent years. //2008//

/2009/
The state very low birth weight rate remained at 1.3 percent, unchanged from the previous year and unchanged in many years. //2009//

Health Status Indicator Measure # 02B
The percent of live singleton births weighing less than 1,500 grams

/2007/
The singleton very low birth weight rate has been 1.0 percent in four out of the last five years, dropping to 0.9 percent only in reporting year 2004. /2007/

/2008/
The singleton very low birth weight rate remained at 1.0 percent, showing no change from the previous year. //2008//

/2009/
The singleton very low birth weight rate declined to 0.9 percent in reporting year 2007, matching the rate for reporting year 2004, and below the 1.0 percent shown for all other reporting years. //2009//

Health Status Indicator Measure # 03A
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger

/2007/
The child death rate was 8.0 or higher between reporting years 2001 and 2004, but in 2005 the rate dropped to 6.1. This decline was sharp, and marked the first time since at least 1990 that the number of child deaths fell below 60. The major reason for the decline was a drop in motor vehicle deaths. /2007/

/2008/
The child death rate was 6.7 in reporting year 2006, rising from the 6.1 of the previous year, but still well below the levels of recent years. //2008//

/2009/
The child death rate due to unintentional injuries declined to 6.3 per 100,000 in reporting year 2007, down from 6.7 in reporting year 2006. It did not decline below the 6.1 achieved in reporting year 2005, but it remained well below the levels found four and five years previously. //2009//

Health Status Indicator Measure # 03B
The death rate per 100,000 for unintentional injuries among children aged 14 years and younger

due to motor vehicle crashes

/2007/
The child death rate was 4.2 or higher due to motor vehicle crashes between reporting years 2001 and 2004, but in 2005, the rate dropped to 3.4, when 33 children died. The number of children who were killed in crashes was the lowest since 1990.

The 2005 rate of 3.4 is undoubtedly the lowest since statistics have been tabulated in this way. In fact, records from the early 1970s in Colorado show at least 60 or 70 children killed each year in motor vehicle crashes. Increased efforts to protect children in cars are to be credited. In particular, the number of deaths to children age 4 or 5, required by law since July 2003 to use booster seats, dropped from an annual count of between 3 and 8 between 1990 and 2003 to 0 in 2004. /2007/

/2008/
The child death rate in reporting year 2006 declined further, to 3.2, reaching a new low point for this age group. The number of deaths, 32, was also a new low. //2008//

/2009/
The child death rate in reporting year 2007 due to motor vehicle crashes remained the same, 3.2, as in the previous reporting year. It is notable that the rate is more than 25 percent lower than just four years previously in reporting year 2003. In 2002, the state legislature passed the child safety booster seat loaw, which went into effect in 2003. In addition, the introduction of univeral anchor systems in motor vehicles in 2002 has provided greater protection to children in crashes. //2009//

Health Status Indicator Measure # 03C
The death rate per 100,000 for unintentional injuries due to motor vehicle crashes among youth aged 15 to 24

/2007/
The death rate for this age group was 27.1 in 2005, little different from the rate in 2004 or the rate in 2001, but lower than the rates in 2002 and 2003. An analysis of rates by single year of age show no trends over the five-year time period. Rates are highly volatile from one year to the next within each age group. /2007/

/2008/
The death rate for youth aged 15 to 24 was 24.4, the lowest rate since 1999. //2008//

/2009/
The death rate for youth due to motor vehicle crashes in reporting year 2007 dropped to 18.7. This represents a substantial decline from the previous year, and nearly a 40 percent decline from four years previously (reporting year 2003). Changes in Graduated Driver Licensing laws (instituted in 1999) are being credited with much of the decline. In 2005, Colorado strengthened the laws to limit passengers riding with inexperienced drivers, to prohibit learners' permit holders to use cell phones while driving, and to require seatbelts for all occupants under age 18. A new driver under age 18 cannot have any passengers under age 21 until the driver has held a driver's license for at least six months. In addition, a new driver under age 18 cannot have more than one passenger under age 32 until the driver has had his license for at least one year. //2009//

Health Status Indicator Measure # 04A
The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger

/2007/
This measure shows a steady downward trend since reporting year 2002. Between reporting year 2002 and reporting year 2005, the rate for children in this age group declined by 15 percent. /2007/

/2008/
The rate of non-fatal injuries for children 14 and younger dropped to 170.7 in reporting year 2006. The decline since reporting year 2002 grew to 21 percent. //2008//

/2009/
The rate of non-fatal injuries for children 14 and younger declined again to 160.9 in reporting year 2007. The decline since reporting year 2003, four years previously, is 19 percent. //2009//

Health Status Indicator Measure # 04B
The rate per 100,000 of all non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger

/2007/
This injury hospitalization rate has been variable in the most recent five years shown. The 2003 rate reached a low of 29.0 per 100,000, but jumped in 2004 to 35.1. The 2005 rate of 32.2 is midway between the two figures. /2007/

/2008/
The rate fell to 28.9 in reporting year 2006. The rate reflects an 86 percent decline since 1996, ten years earlier, when it was 53.7. //2008//

/2009/
The rate fell to 24.9 in reporting year 2007. Since reporting year 2006, the rate fell 14 percent. //2009//

Health Status Indicator Measure # 04C
The rate per 100,000 of all non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years

/2007/
This injury hospitalization rate reached a new low of 170.2 in 2005. The rate can change abruptly from year to year, as seen in the differences between 2002 and 2003 and then between 2003 and 2004. /2007/

/2008/
The injury hospitalization rate for youth posted a real decline, falling to 153.6 in reporting year 2006. This represents a 26 percent decline from ten years earlier. Much more progress has been made, however, with the younger age group. /2008//

/2009/
The rate fell to 144.6 in reporting year 2007, a decline of 6 percent from the previous year. The reporting year 2007 rate marks the fourth consecutive decline since reporting year 2003, when the rate was 186.1. The overall change in just four years amounts to a decline of 22 percent. //2009//

Health Status Indicator Measure # 05A
The rate per 1,000 women aged 15 through 19 with a reported case of chlamydia

/2007/
The chlamydia rate is variable for this age group, but has changed little over the past five years. /2007/

/2008/
The chlamydia rate of 23.1 in reporting year 2006 was similar to rates for this age group in recent years. //2008//

/2009/
The chlamydia rate of 25.6 in report year 2007 is the highest rate shown for the five reporting years. //2009//

Health Status Indicator Measure # 05B
The rate per 1,000 women aged 20 through 44 with a reported case of chlamydia

/2007/
The chlamydia rate for the older age group appears to be increasing. /2007/

/2008/
The chlamydia rate for women 20-44 rose to 9.3 per 1,000 in reporting year 2006. Data submitted in prior grants goes back to 1997, when a rate of 3.7 was reported. The rate has more than doubled in this time period.

/2009/
The clamydia rate for women 20-44 was maintained at 9.3 for reporting year 2007. The rate had been increasing in previous years. //2009//

/2009/ There is no further narrative on the remaining health status indicators, # 06A through # 12. These contain birth, death, population, miscellaneous statistics, poverty, and urban vs. rural data for the state. //2009//

F. Other Program Activities

Toll-Free Hotline

The Family Healthline is a statewide information and referral service located at the Colorado Department of Public Health and Environment. During FY 2004, 8,501 calls were received by the Healthline resource specialist. The Healthline assists women, families, and individuals in locating free or low-cost health care services. Information is provided about other programs such as emergency shelters, food subsidies, mental health, or parenting support groups. The Healthline specialist speaks fluent Spanish and English, and arrangements are made for assisting the hearing- impaired and callers who speak other languages.

The Family Healthline specialist makes referrals, usually within each caller's own community, and can in certain instances establish a direct connection for the caller. Individuals often make repeat calls to the Healthline once they learn the extent of the referral database and the expertise of the staff. The Healthline's referral network covers many categories: low-cost or free medical care, dental health services, domestic violence counseling, and other basic subsistence resources.

The Family Healthline works closely with the Covering Kids and Families program and in some cases, assists individuals in completing the joint Medicaid/Child Health Plan Plus/Colorado Indigent Care Program application form.

Each Healthline call is recorded in a database where demographic and other call information is stored. Monthly reports are generated that detail certain caller demographics (place of residence, Spanish-speaking, etc.) and purpose of the call (Medicaid assistance, immunizations, etc.). These data are useful for program planning efforts. The database software has the capacity to track whether a call is the result of a specific state or national campaign effort. Using the database, the Healthline specialist can refer back to the original call for greater efficiency and better customer service. The database is also used to prepare summary reports.

/2007/
During FY 2005, the Healthline Resource Specialist received 6,355 calls. As of July 1, 2006, the Family Healthline services was transferred to the United Way 211 line. This joint effort will provide more complete personnel coverage for the Family Healthline. The Family Healthline specialist will continue to respond to the majority of the calls with backup provided by the United Way 211 staff. The toll free numbers will remain the same. //2007//

/2008/
Transition of the Family Healthline to United Way went relatively smoothly, however some data was lost due to the move. The following numbers for 2006 are approximate. The Family Healthline offered 6,770 referrals over the year. Of these calls 920 calls were conducted primarily in Spanish. The top three caller needs were for Medical Dental (2362 referrals), food (1990 referrals) and financial assistance (219 Referrals).

Callers are: 86 percent women; 63 percent are unemployed; 77 percent are under 40 years of age; 50 percent are single; and 46 percent are Caucasian.

The average income of callers to the Family Healthline was $12,540 per year. Thus 86 percent of callers earned less than 50 percent of the Denver Metropolitan Statistical Area's median income, which is $56,500 for a single person household. //2008//

/2009/ Since the United Way was no longer interested in managing the Family Healthline, the program posted an RFP and a new contractor, Maximus, was retained as a result of the competitive bid process. The phone line received 8,992 calls between October 2006 to September 2007 an increase over the previous year numer of 6770 calls. //2009//

Sudden Infant Death Program

The Colorado Sudden Infant Death Program is a statewide non-profit 501(c) 3 organization. The program's primary purpose is to provide early intervention through information and counseling to those persons affected by the sudden death of an infant. The program assures that emergency and other first responders understand SIDS and are able to provide accurate and appropriate information and referral resources to the family. Program staff provide the majority of the services to parents, relatives, friends, day care providers, and others. They are assisted by a statewide network of public health nurses, parents, and volunteers.

In FY 2004, the program received 60 information referrals on infant deaths of which 45 were reported as SIDS deaths. Within 48 hours of notification, each family and child care provider was contacted and mailed literature. Every family for whom the program has contact information receives scheduled mailings through the second anniversary of their infant's date of birth.

Over 1,289 contacts (phone and letters) were made in FY 2004. Educational presentations were provided to 248 individuals that included victim advocates, law enforcement officers, health care providers, social services staff, and coroners.

The program held 33 presentations in FY 2004 that offered general and risk reduction information related to SIDS. The presentations reached 727 individuals that included child care providers,

new parents, child birth educators, and the general community.

Risk reduction information is also offered through newsletters, health fairs, and in targeted locations such as stores catering to babies.

/2007/ In FY 2005, the program received 38 referrals on infant deaths of which 27 were determined to be SIDS deaths. Over 1,850 contacts (phone and letters) were made.

Educational presentations were provided to 355 individuals that included victim advocates, law enforcement officers, health care providers, social services staff, and coroners.

The program held 18 presentations that offered general and risk reduction information related to SIDS. The presentations reached 304 individuals that included child care providers, new parents, childbirth educators, and the general community. Risk reduction information is also offered through newsletters, health fairs, and in targeted locations such as stores catering to babies.

The number of SIDS cases reported in 2005 represents a decline from previous years (2003 - 36; 2004 - 41; 2005 - 27). Program staff will be looking into other infant deaths, especially those ruled as undetermined, in order to ascertain if this decrease is related to a diagnostic shift or truly demonstrates a decline in the overall infant mortality rate. This diagnostic shift is seen in other areas of the country and is attributed to the reluctance of some coroners to indicate SIDS as a cause of death if a baby is found in an adult bed or sleeping prone. //2007//

/2008/ There were 32 SIDS deaths in fiscal year 2006. The Colorado SIDS Program provided support to 155 families and trained 327 emergency responders in 51 trainings.

Funding for SIDS will be discontinued after this year because of MCH Block funding reductions. //2008//

Assuring Better Child Health and Development Project (ABCD)
/2008/ The CASH and HCP Units are working to implement the Assuring Better Child Health and Development Project that focuses on promoting the use of standardized developmental screening tools in primary health care settings to help increase early identification of developmental concerns. //2008//

/2009/ The CASH and HCP Units continue to provide leadership for the Assuring Better Child Health and Development Project that focuses on promoting the use of standardized developmental screening tools in primary health care settings to help increase early identification of developmental concerns. With staff support from the MCH Block Grant, as well as funding from two Colorado-based private foundations, the project is in it's second of a three-year statewide rollout. //2009//

G. Technical Assistance

/2009/ Colorado's technical assistance needs are shown on Form 15. The program is seeking assistance in the areas discussed below.

Consultation is requested for effective evaluation techniques to assess progress on performance measures at the state and local levels. The office is not seeking basic information but more advanced expertise. Much data are being gathered and actions are underway, and it is challenging to comprehensively evaluate overall efforts. Consultation with staff from another state that has more experience in long-term evaluation of multi-dimensional MCH activities may be helpful, as would guidance from a national expert on MCH evaluation.

Access to care remains an important public health assurance function and an MCH essential service. Several local agencies have identified these activities as a priority area. MCH would value assistance in determining how to best structure efforts to support access to care activities at the infrastructure building versus the enabling service level. //2009//

V. Budget Narrative

A. Expenditures

Information on annual expenditures is contained in Form3, Form 4, and Form 5.

//2009/

FY 2007 expenditures were allocated 9.83% to Administration; 30.87% to Children with Special Health Care Needs; 31.24% to Child and Adolescent and 28.07% to Maternal and Infant Services.

Form 3

Line 1 - Federal Allocation - Total expenditures in FY 2007 were slightly higher than those budgeted for the year. The Federal Allocation was $997 lower than budgeted ($7,327,232 vs. $7,326,235); and the Local MCH Funds were $747 higher than budgeted ($759,363 vs. $758,616).

Line 9 - Other Federal Funds - The large variation between budgeted and expended ($22,197,426 vs. $101,434,746) is due to the Women, Infants & Children (WIC) and the Child & Adult Care Food Program (CACFP) being placed under the administration of the MCH Director. $95,073,170 of the expended amount is attributed to WIC & CACFP.

Form 4

Line 1. a. - Pregnant Women - Total expenditures in FY 2007 for pregnant women was less than budgeted due to substantial vacancy and contractual savings. Funds were redirected to provide additional services in the category children 1 to 22.

Line 1. c. - Children age 1 to 22 - Vacancy and contractual savings from the pregnant women category were rebudgeted and expended in this area. Additional child health opportunities were identified. With efforts to develop public and private partnerships, the program was able to increase services to this population.

Line 1. d. Children with special health care needs - budget vs. expended did not substantially vary.

Line 1. f. Administration - Budget vs. expended varied due to indirect costs associated with State Funds (Genetic testing) that were overestimated due to the use of the wrong indirect cost rate when budgeting for the year 2007. Actual indirect expenses were about $143,000 less than budgeted.

Form 5

Line 1 - Direct Health Care Services - Although Colorado's local health departments' local match expenditures are continuing to move from direct and enabling services to infrastructure services, actual direct serves were higher than originally projected. Prior to federal fiscal year 2007, the trend year-to-year was a steady decrease of direct health care services into other service areas. Analysis has now shown that direct health care services have leveled off. Budgeting for 2009 has been adjusted based on this trend.//2009//

B. Budget

Budget information is contained in Forms 2, 3, 4, 5, and 10.

Line 1 - Federal allocation - is shown at $7,230,230 for 2009. Of these dollars, a total of 33.72 percent will be allocated for preventive and primary care for children; 31.72 percent for children with special health care needs, and 9.19 percent will be spent on administration. These proportions meet the MCH Block Grant requirements.

Line 3 - State MCH Funds - show state funds of $4,736,061 and local funds of $686,612 meeting the requirement that the total amount of $5,422,673 equals three-fourths of the federal allocation. The state maintenance of effort from 1989 is $4,736,061. The total state match for FY 07 is $4,736,061, which is the same amount.

Line 7 - Total state match - consists of state general funds in the amount of $3,339,543 and cash funds in the amount of $1,396,519 (genetics counseling fees). Local funds that support prenatal and child health activities conducted at local health departments total $686,612.

Line 9. a. Other Federal Funds - the CISS grant line is the State Early Childhood Comprehensive System Grant.

Line 9. i. Centers for Disease Control - funds include $257,504 for National Violent Death Registry Grant; $337,113 for Enhancing State Capacity to Address Child & Adolescent Health through Violence Prevention Grant; $125,137 for Traumatic Brain Injury Grant; $48,650 for Injury Surveillance Grant; $134,695 for Injury Prevention Grant; $101,365 for Rape Prevention and Education Grant; and $563,500 for Sexual Violence Prevention.

Line 9. k. - Other - the program will receive $1,074,900 for Community-Based Child Abuse Programs from the Administration for Children and Families, Office of Child Abuse and Neglect; $105,329 from the Preventive Block Grant; $575,714 for Youth Suicide Prevention; and $3,167,153 of Title X funds.

Assurances:
The Colorado Department of Public Health and Environment will spend these funds as they are presented in this application.

The Colorado Department of Public Health and Environment uses a funding formula based on the total number of children and women of childbearing age and the number of low-income children and women of childbearing age to distribute the majority of available funding. However, some funds are distributed in compliance with Colorado's Procurement Rules and involve a "Request for Applications" competitive process such as for fund distribution to the School Based Health Centers program.

The department will only use these funds to carry out the purposes of Title V.

The department publishes sliding-fee schedules for all services for which charges are made. Charges will not be imposed on low-income mothers and children, and will be adjusted to reflect the income, resources, and family size of individuals.

Department grantee audits are performed every two years, except when the grantee falls under the Single Audit Act provisions of Federal law.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.